

# HARM REDUCTION DEVELOPMENTS 2005

Countries with Injection-Driven HIV Epidemics



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# **HARM REDUCTION DEVELOPMENTS 2005**

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# Contents

<b>International Harm Reduction Development Program: Mission and Strategies</b>	<b>1</b>
<b>From the Directors</b>	<b>5</b>
<b>Harm Reduction Developments: International Policy</b>	<b>9</b>
No Condoms, Needles, or Human Rights for Drug Users at the 48th Session of the Commission on Narcotic Drugs	9
UNAIDS Prevention Strategy, Including Clean Needles, Wins U.S. Approval	10
U.S. Needle Exchange Opponent Convenes Congressional Attack on Harm Reduction	12
WHO Adds Methadone and Buprenorphine to Essential Medicines List	14
EU Action Plan: Harm Reduction, Drug Services, and Alternatives to Imprisonment Critical	14
UN Task Force: Millennium Development Goals Require Drug Policy Reform and Needle Exchange	15
<b>Harm Reduction Developments: Central and Eastern Europe and the former Soviet Union</b>	<b>17</b>
Central Asia	18
Georgia	23
Russia	24
Ukraine	29
Country Briefs	31
<b>Harm Reduction Developments: Asia</b>	<b>33</b>
China	34
Indonesia	38
Iran	40
Malaysia	44
Vietnam	46
<b>Harm Reduction Overviews</b>	<b>49</b>
Community Mobilization: Organizations of Drug Users and People with HIV	50
ARV for IDUs	53
Prisons, HIV, and IDUs	55
Substitution Treatment	59

## Voices from the Front

Russian Activist at UN: No Plan, Great Indifference, Many Lives Lost	11
USAID: Work with Drug Users is Essential to Combating HIV	15
ITPC Finds Gaps in Treatment Preparedness in Russia	28
Playing God in Kathmandu	37
Head of Iranian Judiciary Urges Prosecutors Not to Impede Harm Reduction	42
Is Harm Reduction “Un-Muslim?” A Malaysian Infectious Disease Expert Offers Religious Grounds for Action	45
Consulting with People Who Use Drugs: Recommendations for Effective Engagement	52
A STEP Toward Equitable Treatment Access	54
From Research to Action on Prison Needle Exchange	58

## Tables and Graphs

IDUs as Percent of Total Registered HIV Cases CIS Countries, December 2005	22
Percent of IDUs Reached by Needle/Syringe Programs Select CIS Countries, December 2005	25
Funding for Harm Reduction Programs in Russia, 2002–2005	26
IDUs as Percent of Total Registered HIV Cases Select Asian countries, 2005	43
Harm Reduction in Prisons: Developing/Transitional Countries with Injection-Driven HIV Epidemics, 2005	57
Availability of Opiate Substitution Treatment: Developing/Transitional Countries with Injection-Driven HIV Epidemics, December 2005, Central and Eastern Europe and the former Soviet Union	61
Availability of Opiate Substitution Treatment: Developing/Transitional Countries with Injection-Driven HIV Epidemics, December 2005, Asia	62

## List of Acronyms

<b>ARV</b>	antiretroviral therapy (HIV)
<b>CEE/FSU</b>	Central and Eastern Europe and the former Soviet Union
<b>CEEHRN</b>	Central and Eastern European Harm Reduction Network
<b>CHALN</b>	Canadian HIV/AIDS Legal Network
<b>CIDA</b>	Canadian International Development Agency
<b>CIS</b>	Commonwealth of Independent States
<b>CND</b>	Commission on Narcotic Drugs (United Nations)
<b>DFID</b>	Department for International Development (United Kingdom)
<b>EATG</b>	European AIDS Treatment Group
<b>EU</b>	European Union
<b>GFATM</b>	Global Fund to Fight AIDS, Tuberculosis and Malaria
<b>HCV</b>	hepatitis C
<b>IDU</b>	injecting drug user
<b>IHRD</b>	International Harm Reduction Development Program
<b>NGO</b>	nongovernmental organization
<b>ONDCP</b>	Office of National Drug Control Policy (United States)
<b>OSI</b>	Open Society Institute
<b>PEPFAR</b>	The President's Emergency Plan for AIDS Relief (United States)
<b>PLWHA</b>	people living with HIV/AIDS
<b>RHRN</b>	Russian Harm Reduction Network
<b>TDN</b>	Thai Drug Users Network
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNDP</b>	United Nations Development Programme
<b>UNODC</b>	United Nations Office on Drugs and Crime
<b>USAID</b>	United States Agency for International Development
<b>WHO</b>	World Health Organization

## Sources

Information contained in this report was obtained from a variety of sources, including grant reports from the Global Fund to Fight AIDS, Tuberculosis and Malaria (available online at [www.theglobalfund.org](http://www.theglobalfund.org)); national AIDS and narcological centers; ministries of health; national prison authorities; media reports; and in-country correspondents contacted directly by IHRD.

Estimates of IDUs are from “Estimated IDU and HIV Prevalence among General Populations and in Prison Settings,” included in materials of the 3rd International Policy Dialogue: HIV/AIDS in Prisons (Toronto, October 16-19, 2005). Data was compiled by the HIV/AIDS Unit, United Nations Office on Drugs and Crime (UNODC), September 13, 2005.

Population estimates are from the United Nations 2005 report, *Population and HIV/AIDS 2005*. New York: Population Division, United Nations Department of Economic and Social Affairs.

Estimates of substitution treatment availability in CIS countries are drawn from reports by national narcological centers; Soros foundations; the Central and Eastern European Harm Reduction

Network (Baltics and Belarus); the Krakow Association for Drug User Support (Poland); and the AIDS Outreach Program (Moldova). Asian estimates are from UNODC; the European Network on Drugs and Infections in Prison; the Malaysian AIDS Council; and local programs.

Where in-country data on HIV cases attributable to IDU was unavailable from local sources, figures for CIS countries are drawn from Srđan Matic’s 2005 power-point presentation “Taking the Agenda Forward” at the WHO European Regional Planning and Technical Consultation (Berlin, October 5, 2005).

Ralf Jürgens, the former executive director of the Canadian HIV/AIDS Legal Network, contributed to the section on Prisons, HIV and IDUs.





Needle exchange client holding referral to medical care, Bishkek, Kyrgyzstan



## International Harm Reduction Development Program: Mission and Strategies

In increasing numbers of countries in Asia and the former Soviet Union, HIV epidemics are driven by injecting drug use. UNAIDS has noted that the Russian Federation's HIV epidemic is the fastest growing in the world: as many as 1.2 million people there are estimated to be living with HIV, more than in the United States and Canada combined. Virtually all were infected in the last eight years. Eighty percent of all registered HIV cases are among those under the age of 30. Almost nine in ten are injecting drug users (IDUs).

Outside of Africa, UNAIDS estimates that one of three HIV infections is now due to injecting drug use. Contaminated injection equipment accounts for the largest share of HIV infections in China, Indonesia, Malaysia, Ukraine, the Baltic States, the Caucasus, Central Asia, much of South and Southeast Asia, and the Southern Cone of South America.

Founded in 1995, the International Harm Reduction Development Program (IHRD) of the Open Society Institute (OSI) works to reduce HIV and other harms related to injecting drug use, and to press for policies that reduce stigmatization of illicit

drug users and protect their human rights. IHRD, which has supported more than 200 programs in Central and Eastern Europe, the former Soviet Union, and Asia, bases its activities on the philosophy that people unable or unwilling to abstain from drug use can make positive changes to protect their health and the health of others. Since 2001, IHRD has prioritized advocacy to expand availability of needle exchange, opiate substitution treatment, and treatment for HIV; to reform discriminatory policies and practices; and to increase the political participation of people who use drugs and those living with HIV.

## Reducing Harm Through Service

### *Needle exchange, substitution treatment, overdose prevention, and legal support*

An overwhelming body of scientific evidence supports the efficacy of needle exchange and opiate substitution treatment in reducing HIV risk. Services that IHRD has supported include:

- needle exchange programs across Central and Eastern Europe and the former Soviet Union;
- substitution treatment with methadone or buprenorphine in countries including Albania, Kyrgyzstan, Lithuania, and Ukraine;
- the formation of harm reduction networks in Central and Eastern Europe, Russia, and Central Asia to help programs exchange information and advocate for change;
- prison-based harm reduction programs, including needle exchange in Kyrgyzstan and Moldova;
- counseling and outreach efforts to reach drug users, their families, and friends with accurate information about HIV, hepatitis C, and overdose;
- legal services programs to help fight discrimination and prevent legal abuses; and
- trainings for police, HIV physicians, drug treatment specialists, and harm reduction program staff.

## Reducing Harm Through Technical Assistance

### *New models of treatment for HIV and drug dependence*

Support from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)

and from bilateral and multilateral donors such as the UK's Department for International Development (DFID) and the World Bank has greatly increased funding available for harm reduction. The need for assistance in scaling up such services at the country level, however, remains acute.

Technical assistance provided by IHRD has facilitated:

- expansion of antiretroviral treatment (ARV) in Russia, and the development of the first HIV treatment protocols that include drug users;
- integration of programs providing HIV prevention, HIV treatment, opiate substitution treatment, and care for tuberculosis in Ukraine;
- support in the preparation and implementation of Global Fund grants on harm reduction in Azerbaijan, Georgia, Moldova, Russia, Tajikistan, Thailand, and Ukraine; and
- bilateral funding of harm reduction initiatives in Central Asia, and monitoring to ensure that the money is used appropriately.

## Reducing Harm Through Advocacy

### *Policies based on evidence rather than ideology*

Harm reduction programs cannot be effective if fear of harassment, arrest or incarceration makes drug users reluctant to use them. IHRD has worked with policymakers at local, provincial, national, and international levels to:

- encourage the United Nations and national governments to support proven measures such as syringe exchange and substitution treatment at the UN Commission on Narcotic Drugs, the Human Rights Commission,

the UNAIDS Programme Coordinating Board, and in national plans;

- highlight the role that incarceration and forced institutionalization play in accelerating the HIV epidemic, and the policy changes that can reduce overcrowding, disease risk, and human rights violations;
- increase funding for and political commitment to the provision of HIV prevention, treatment, and care for IDUs; and
- sponsor or co-sponsor policy dialogues, conferences, satellite sessions, and study tours to explore solutions and demonstrate lessons learned in harm reduction.

## Reducing Harm Through Community Organizing

### *Support for drug users and people living with HIV*

More than two decades of HIV have shown that so-called “hard to reach” populations are often their own best advocates. Despite the importance of involving those directly affected in the formation of AIDS policy, drug users often have been excluded from even those mechanisms that are supposed to increase the participation of people living with HIV.

IHRD has supported active participation of affected communities by offering:

- funding and technical support to organizations of drug users and people with HIV in 13 countries of Eastern Europe, the former Soviet Union, and Asia. Groups work on issues as varied as overdose prevention, HIV treatment advocacy, and media campaigns;
- sponsorship of participation of people who use drugs and people with HIV in international conferences as well as in regional and national conferences in Asia and the former Soviet Union;
- work with groups such as the European AIDS Treatment Group, the Global Network of People Living with HIV/AIDS (GNP+), and the Collaborative Fund for HIV Treatment Preparedness/International Treatment Preparedness Coalition on programs to increase HIV treatment literacy, ensure transparent and effective procurement of ARV, and challenge the systematic exclusion of drug users from care; and
- training and grants to support community mobilization, monitoring of the Global Fund and other HIV programs, and documentation of human rights abuses.

***For more information on the International Harm Reduction Development Program, see [www.soros.org/harm-reduction](http://www.soros.org/harm-reduction)***



Harm reduction program in Togliatti, Russia

# From the Directors

UNAIDS, in its *AIDS Epidemic Update: December 2005*, put the total number of HIV-positive people in the world at 40.3 million and estimated that 5 million were infected in 2005 alone. These numbers are horrifying, but not surprising. Although for years we have known how to prevent HIV transmission, we have done a terrible job in translating knowledge into action. Jim Yong Kim, WHO's outgoing director for HIV/AIDS, said the 5 million new cases in 2005 showed that global HIV prevention efforts have “failed, failed, failed.”

The reasons why these efforts have “failed” are now familiar: lack of political will and leadership, discrimination against people living with HIV and those vulnerable to infection, limited access to treatment, and substandard efforts to provide HIV prevention services to those in need. None of these issues is easy to address, especially in the resource-poor countries that continue to bear the brunt of the HIV epidemic.

An important step toward improving global prevention is to know where, how, and why HIV is spreading—and what,

if anything, is being done to halt the epidemic. This report provides a snapshot of some key developments in HIV prevention for injecting drug users (IDUs) in 2005. IDUs comprise 10 percent of all global HIV cases, a number that rises to 30 percent outside of sub-Saharan Africa. The fact that needle sharing is an especially efficient method of transmitting HIV means that epidemics among IDUs are also explosive. Once HIV is introduced into a drug-using network, HIV prevalence can surge from zero to 50 percent in a matter of months.





Outreach worker and volunteers, Bishkek, Kyrgyzstan

Just as stark as HIV prevalence surveys, however, are studies showing that comprehensive harm reduction interventions can drastically cut rates of HIV infection among IDUs. In few other areas of HIV prevention has the evidence been so clear. Increased access to needle/syringe exchange and opiate substitution treatment sharply reduces IDUs' likelihood of contracting HIV and greatly improves their health and public health in general.

Nevertheless, harm reduction remains controversial in most of the world. Policymakers frequently claim that services such as needle exchange encourage illicit drug use or fail to adequately punish those who break the law. Others claim that any approach that does not require abstinence from drug use represents a moral failure. This argument ignores the moral costs of failure to make available needle exchange,

substitution treatment or overdose prevention, thus causing illnesses and deaths that might easily have been prevented.

IDUs comprise the largest share of total HIV cases in some 20 nations of Asia and the former Soviet Union. In countries such as Russia and Ukraine, the epidemic, though young, can fairly be described as fully established, and AIDS deaths have already begun their devastating impact on individual health and economic development. In others, such as the Central Asian republics and certain countries in Southeast Asia, HIV prevalence and AIDS cases remain comparatively low, but are steadily rising among IDUs and other vulnerable populations.

Efforts to address injection-driven epidemics vary widely, from repressive law enforcement measures to those informed by respect for human rights or public health

evidence. With support from international and domestic organizations, drug users and their allies are mobilizing to articulate their needs and demand appropriate policies and resources. Grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria were particularly important in initiating or expanding harm reduction services in 2005. Funds coming from Geneva, however, are only as effective as those programs working to turn them into harm reduction services at the country level. Here, as these pages show, much remains to be done.

This report focuses on countries where IHRD or our local partners work, and in no way provides a complete record of global harm reduction developments. Important harm reduction organizations and networks operate across Asia and Latin America without support from or engagement with the Open Society Institute. Further, many countries where IDUs are not a majority of HIV cases—including Burma, Cambodia, India, and Pakistan—are excluded here, but nonetheless have significant numbers of HIV infections among IDUs and important initiatives underway by harm reduction advocates and service providers. Despite the narrow focus of the report, we hope the information will be useful to all those

seeking to scale up prevention, treatment, and human rights protection for IDUs.

More than the health of drug users is at stake. In 2005, many countries with epidemics concentrated primarily among IDUs reported increasing numbers of HIV cases among women infected sexually. Reluctance to provide drug users with services has proved to be a punishment delivered also to the families of drug users, and to whole communities. The appropriate response as HIV epidemics become less concentrated, however, is not to raise alarm about “generalizing” epidemics and to turn away from efforts targeted to IDUs. Rather, countries must reckon honestly with the fact that the women and children who represent the new wave of infections are themselves primarily the sexual partners and children of people who use drugs. General AIDS awareness messages are no substitute for appropriate HIV prevention and treatment services for IDUs.

As the philosopher George Santayana observed a century ago, “Those who cannot remember the past are condemned to repeat it.” We hope that that this report will help us recognize the missed opportunities of the past, and galvanize more impressive steps in the future.

*Kasia Malinowska-Sempruch, Director*

*Daniel Wolfe, Deputy Director*

*International Harm Reduction Development Program*





HIV treatment activists in Moscow, Russia

# Harm Reduction Developments: International Policy

Injection-driven HIV epidemics are frequently found in nations that rely on assistance from abroad to address public health needs. As a result, the inclination and ability of individual countries to support harm reduction are greatly influenced by the policies of multilateral institutions and wealthy nations.

The world's largest supporter of HIV programs, the U.S. government, does not allow its financial assistance to be used to pay for sterile injection equipment. Some U.S. officials in 2005 also sought to limit international commitments to harm reduction, working to strike language about sterile syringes from United Nations documents and suggesting that recipients of U.S. aid should also refrain from using monies from other sources for needle and syringe programs. In Europe, by contrast, governments presented a virtually united front in 2005 in support of harm reduction. Meetings of UN bodies, where global consensus is sought, became the battlefield where these competing views were expressed.

## No Condoms, Needles, or Human Rights for Drug Users at the 48th Session of the Commission on Narcotic Drugs

Although little-known among HIV activists, the Commission on Narcotic Drugs (CND) shapes global AIDS policy in the increasing number of countries with injection-driven HIV epidemics. The 53-member body sets the agenda for the UN Office on Drugs and Crime (UNODC), a co-sponsor of UNAIDS and the member of the UN “family” designated the primary source of technical assistance for HIV prevention among IDUs. The 2005 meeting of the CND, held in March in Vienna, was particularly important because HIV prevention among drug users was a special focus of debate.

The anti-harm reduction campaign by the United States began well in advance of the meeting itself. In November 2004, U.S. Assistant Secretary of State Robert Charles visited UNODC Executive Director Antonio Maria Costa. The day after his visit, Costa sent a *mea culpa* to Charles pledging that UNODC would be “even more vigilant” in policing web pages and publications for the term “harm reduction.” Shortly thereafter, a senior staff member at UNODC sent an email to regional offices, reminding them to avoid positive references to needle exchange or harm reduction in UNODC printed and electronic statements.

Efforts by the Bush administration to make its particular ideology into the global standard elicited strong reactions from NGOs and governments. A coalition of groups including Human Rights Watch, the Canadian HIV/AIDS Legal Network, the International Harm Reduction Association, the Asian Harm Reduction Network, Gay Men’s Health Crisis, the European AIDS Treatment Group, and OSI circulated a sign-on letter endorsed by more than 350 organizations and individuals from 56 countries urging that the U.S. position be challenged.

OSI President Aryeh Neier, in an opinion piece in the *International Herald Tribune*, warned that American policies failed to grasp the global realities of the world’s HIV crisis, while editorials in the *New York Times* and the *Washington Post* condemned the Bush administration for “flat-earthism” and ideological bullying. “The United States should help pay for these important programs,” the *Times* concluded. “If it cannot bring itself to do so, it should at least allow the rest of the world to get on with saving millions of lives.”

Governments also responded. In the debate on HIV prevention at the CND meeting, 17 of 30 speakers, including those representing Australia, the European Union, and the United Kingdom, directly supported

needle exchange or harm reduction. Former opponents such as China, Iran, Libya, and Sweden indicated support or openness to further exploration of the approach. Brazil proposed a resolution, “HIV/AIDS and the Right to Health,” that called for the increased availability of clean needles for drug users. The proposal won support from a group of Latin American and Caribbean nations and most countries of the EU, as well as from Canada, Iran, and Nigeria, among others.

While these efforts heightened attention to the U.S. government’s obstructive position, they did not carry the day. In public, U.S. drug czar John Walters refrained from attacking needle exchange, and U.S. officials voiced strong support for substitution treatment. In private, though, delegates from other countries reported that U.S. representatives remained immovable, insisting that any mention of needle exchange, harm reduction, or even the word “harm” be deleted from all CND resolutions. Washington representatives also deemed mention of the human rights of drug users unacceptable, and consistently sought to replace the term “HIV prevention” with references to drug abuse prevention and treatment. Negotiating with the United States, a Latin American delegate recalled later, was “like taking a beating.”

In the end, the United States prevailed. No resolution at the CND mentioned needle exchange, condoms, or the human rights of drug users.

### [UNAIDS Prevention Strategy, Including Clean Needles, Wins U.S. Approval](#)

Having witnessed successful U.S. efforts to remove all mention of sterile injection equipment from resolutions at the Commission on Narcotic Drugs (CND) in March 2005, advocates were prepared for another battle over the adoption of the UN’s

# voices from the front

## RUSSIAN ACTIVIST AT UN: NO PLAN, GREAT INDIFFERENCE, MANY LIVES LOST

*The following text is from a speech delivered on June 2, 2005, at a high-level meeting of the UN General Assembly to review progress toward the UN's 2001 Declaration of Commitment on HIV/AIDS. The speaker, Russian activist Anya Sarang, was the coordinator of the Steering Committee of the Central and Eastern European Harm Reduction Network.*

I would like to raise a point about injecting drug users. I come from Russia—a country where [more than] 80 percent of HIV cases are related to injecting drug use and access to adequate HIV prevention for this group represents the central element of effective HIV prevention in general. While some countries in our region can demonstrate good examples of scaling up services for IDUs, as promised in 2001, my own country is not among them.

Ironically, the scale of services such as needle exchange in Russia has been shrinking rather than increasing over the last five years.... Substitution treatment, which is high on the list of evidence-based prevention strategies, is illegal in Russia. There is no national HIV plan to ensure inclusion of drug users into prevention programs. Hundreds of thousands [are imprisoned] for minor drug offenses, and no prevention is provided within prison walls, where IDUs are even more vulnerable to HIV. All this illustrates how my country effectively fails to adhere to its 2001 commitments.

But my country is not unique in this regard. We all have read the appalling figures in the Secretary General's report: in 2003, targeted prevention services reached only 16 percent of sex workers and only 5 percent of IDUs. So we should ask ourselves today: Why is this happening? Why are highly effective and evidence-based interventions such as needle exchange and substitution treatment not taken up by our governments, as promised?

Is it because drug users and sex workers are considered "marginal" and disposable members of societies, and not even thought of as eligible for human rights protection?

Is it because of the legal barriers and unwillingness to challenge them? Do governments fear becoming unpopular among the electorate and

therefore prefer to sacrifice a detested part of the population rather than to provide leadership in building humane and fair societies?

Is it because the countries possess few resources or, more likely, little desire to allocate any resources for these politically difficult interventions?

Is it because some governments, such as the United States, not only restrict access to effective prevention for groups such as drug users and sex workers within their own country, but also impose such policies on poor and economically dependent countries?

Is it because countries place greater priority on other international commitments, such as drug conventions that are often interpreted by governments as justification to employ a simple and straightforward approach to drug users: catch them and lock them up? In many countries this approach is implemented much more vigorously than promised HIV prevention.

Is it because in most democratic societies drug users or sex workers are not even invited when important discussions directly influencing their lives such as this one are taking place?

And honestly, is this happening because at the end of the day nobody will be held accountable for the mass murder that is taking place while we observe and document it occurring? The governments will blame lack of resources; UN officials will humbly nod toward the governments; civil society will say "we did all we could;" and everybody will go home hoping that next time we'll do better. But for many there will be no next time. Many will die and suffer while we get around to our business. I think today we should honestly admit our failure, be more realistic, and really mobilize ourselves so by the next year and onwards we can see at least some progress in reaching the prevention goals.

global HIV prevention strategy in Geneva in June. The group responsible for the strategy, the UNAIDS Programme Coordinating Board (PCB), split after U.S. officials in preliminary meetings insisted that all references to needle exchange be removed from the document.

In the United States, a coalition of HIV prevention, drug policy, and human rights groups—including the Harm Reduction Coalition, Human Rights Watch, Gay Men's Health Crisis, and OSI—issued a sign-on letter urging U.S. Global AIDS Coordinator Randall Tobias not to allow ideology to trump scientific evidence. Advocates also succeeded in drawing the attention of lawmakers and the U.S. media. Rep. Henry Waxman (D, CA), the ranking minority member of the House Committee on Government Reform, sent a letter to U.S. Secretary of State Condoleezza Rice to emphasize the dangers of replacing science with ideology at UNAIDS. Waxman noted that 17 major reviews and assessments of needle exchange had supported the effectiveness of needle exchange in reducing HIV risk without encouraging drug use. A June 27 *New York Times* editorial referred to U.S. efforts to force a retreat from needle exchange as “a breathtakingly dangerous step.”

In Europe, HIV prevention experts briefed delegations from other member states to underscore the dangers of U.S. attacks on access to sterile needles and injection equipment. NGO advocates and UN representatives also worked the hallways at the meeting itself.

In the final discussions at the Geneva meeting, the United States faced virtually unanimous opposition. The Netherlands proposed language about a comprehensive approach to HIV prevention that included sterile injection equipment, while Canada added the importance of “respect for human rights of drug users.” Delegates from Europe and Australia, where needle

exchange has contained the HIV epidemic to a much greater extent than in the United States, were particularly forceful. Norway noted that it would be “irresponsible” not to base HIV prevention on scientific evidence, and Finland suggested that to remove mention of sterile injection equipment would be “unethical.” Even Senegal, a country with few documented cases of HIV via injection, urged the UN to stick to the language in favor of harm reduction adopted by all nations, including the United States, at the 2001 UN General Assembly Special Session on HIV/AIDS.

Confronted by a unified front in Geneva and growing criticism at home, U.S. officials limited their objections to a footnote, recorded in the meeting minutes, saying that the United States “cannot be expected to fund activities inconsistent with its own national laws and policies.”

The language of the strategy itself, adopted on June 29, recognized the importance of the availability of access to sterile injection equipment and measures to protect the human rights of drug users.

Considered together, the defeat for needle and syringe programs at the CND and support for them at the UNAIDS meeting highlighted the divisions within the UN system itself on the issue of harm reduction. The split between drug control and HIV prevention in 2005 was often duplicated at the national level, hampering efforts to protect the health of IDUs.

### [U.S. Needle Exchange Opponent Convenes Congressional Attack on Harm Reduction](#)

In the United States, long-time needle exchange opponent Rep. Mark Souder (R, IN) turned his sights on the international arena in 2005. As chairman of the House Committee on Government Reform's Subcommittee on Criminal Justice, Drug





Police rounding up suspected drug users at a nightclub, Moscow, Russia

Policy, and Human Resources, Souder convened a hearing to criticize harm reduction and launched an investigation into U.S. Agency for International Development (USAID) support for the approach.

The February hearing entitled “Harm Reduction or Harm Maintenance?” largely served as a platform for Souder to assert, without evidence, that harm reduction programs were a Trojan horse for drug legalization. An array of witnesses called by the Republicans argued, among other things, that harm reduction was morally suspect and ineffective. In testimony that astounded and provoked rebuttals from HIV experts (*see page 45*), witnesses called by Souder, including a Malaysian drug treatment provider, testified that needle exchange violated Hindu and Muslim religious beliefs, that there were few IDUs in Asia, and that the United States

was “bullying” other countries into adopting harm reduction.

Many in the chamber, including those wearing “clean needles saved my life” buttons, perceived the bullying to be in the opposite direction. Witnesses called by the Democrats, among them drug treatment providers, epidemiologists, and health officials, highlighted the overwhelming scientific evidence for harm reduction and presented a sobering picture of the rapidly growing HIV epidemic in Asia and the former Soviet Union. Souder responded by accusing several Democratic witnesses of favoring drug legalization, and vowed to investigate further.

Though the hearing lasted only a day, efforts to discredit harm reduction may not be over. Prior to the hearing, Souder had demanded that USAID assemble, on searchable CD-ROM, all written records,

correspondence, and emails mentioning OSI or its affiliate the Alliance for Open Society International (AOSI), the International Harm Reduction Association, the Asian Harm Reduction Network, and several other organizations. While USAID strongly defended its work with IDUs, the demand forced agency staff and grantees to turn from work on HIV prevention to exhaustive documentation. Staff members of AOSI, for example, were required to duplicate some 25,000 pages from their Kazakhstan office alone.

### WHO Adds Methadone and Buprenorphine to Essential Medicines List

Months of data collection and advocacy by community groups paid off in June 2005, when the World Health Organization (WHO) announced the addition of methadone and buprenorphine to its 14th Model (Complementary) List of Essential Medicines in June 2005. Advocates hoped the change would end the debate over the lifesaving potential of these substitution treatments and expand their availability in the many countries where they are restricted or banned (*see Substitution Treatment, page 59*).

The change was the culmination of nearly two years of advocacy by people living with HIV, drug users, and their allies. In November 2003 a small group met with WHO's director-general, Jong Wook-Lee, and urged inclusion of methadone and buprenorphine on the list of essential medicines. This goal was supported by an international campaign that included Human Rights Watch, the European AIDS Treatment Group, the Central and Eastern European Harm Reduction Network, the Asian Harm Reduction Network, the International Harm Reduction Association, OSI, and dozens of local groups. More than

300 organizations and individuals signed a letter backing the campaign, and regional organizations collected and compiled reports for WHO that summarized evidence of the medications' effectiveness and offered technical advice on their administration.

The WHO List of Essential Medicines, updated every two years since its initial publication in 1977, contains 312 medicines deemed indispensable for cost-effective medical treatment. The complementary category, to which methadone and buprenorphine were added, includes medicines that require some specialized diagnostic and/or monitoring facilities for their use.

### EU Action Plan: Harm Reduction, Drug Services, and Alternatives to Imprisonment Critical

Harm reduction won an important source of support in June, when the Council of the European Union (EU) endorsed the Drugs Action Plan. Drafted in response to advocacy by EU member states and a call by the European Parliament to place greater emphasis on scientific evidence in the formation of a response to illicit drugs, the plan has three objectives explicitly supporting harm reduction:

- Objective 13: "Further develop alternatives to imprisonment for drug abusers and drug services for people in prisons, with due regard to national legislation." Two steps were recommended to realize this goal: "1. Make effective use of and develop further alternatives to prison for drug abusers; and 2. Develop prevention, treatment and harm reduction services for people in prison, reintegration services on release from prison and methods to monitor/analyze drug use among prisoners."



# voices from the front

## **USAID: WORK WITH DRUG USERS IS ESSENTIAL TO COMBATING HIV**

*Under attack by opponents of harm reduction, USAID confirmed that it does not provide funding for needle exchange, but strongly defended partnership with needle exchange programs:*

“Injecting drug use accounts for 70 to 90 percent of HIV infections in [Central Asia], therefore IDUs must be reached to combat the epidemic. Existing needle exchange sites offer an important opportunity to conduct further interventions with IDUs. Organizations that establish trust and gain access to the hard-to-reach population can serve as a conduit for other information, counseling, and referrals . . . .”

- Objective 14: “Prevention of health risks related to drug use,” to be achieved by “implementation of the Council Recommendation on the prevention and reduction of health-related harm associated with drug dependence.”
- Objective 15: “Availability and access to harm reduction services,” to be achieved by “improved access for addicts to all relevant services and treatment options designed to reduce harm, in due regard with national legislation.”

Civil society groups in 2006 will work to ensure that the EU turns these pledges into meaningful programs.

### **UN Task Force: Millennium Development Goals Require Drug Policy Reform and Needle Exchange**

A report released in June by a high-profile UN task force endorsed harm reduction as a vital and effective HIV prevention strategy. The report, *Combating AIDS in the Developing World*, was prepared for

the UN Millennium Project’s Task Force on HIV/AIDS, Malaria, TB, and Access to Essential Medicines.

The task force included HIV prevention leaders such as International AIDS Society President Helene Gayle, Kasia Malinowska-Sempruch of IHRD, and Katherine Hankins of UNAIDS. Their report identified needle exchange and opiate substitution treatment as “the single highest priority in Russia, Ukraine, much of China and Southeast Asia, as well as in large parts of India and Latin America.” More strikingly, the report included three recommendations for policy reform: decriminalizing of syringe and needle possession at the national level, more active work by the UN to promote the expansion of harm reduction programs, and the rescheduling of methadone to a less restrictive category at the Commission on Narcotic Drugs.

The task force was part of a larger effort to advance the goals of the UN’s Millennium Development Project, a cooperative effort begun in 2000 to markedly improve global human development conditions by 2015.



Outreach workers for a harm reduction program in Khojand, Tajikistan

# Harm Reduction Developments: Central and Eastern Europe and the former Soviet Union

Over the past decade, the twin epidemics of HIV and injecting drug use have had perhaps their most lethal effects in countries in Eastern Europe and the former Soviet Union. Estonia and Ukraine, for example, share the dubious distinction of having an estimated HIV prevalence of 1.4 percent of the population, the highest in Europe. Year after year, UNAIDS has distinguished the epidemics in the former Soviet Union as the fastest growing in the world.

Estimates by UNAIDS suggest that HIV prevention efforts need to cover 60 percent of IDUs in order to effectively contain injection-driven epidemics. Yet no country in the former Soviet Union reaches more than a third of IDUs with needle exchange services. Even those counted as “reached” often have intermittent access to sterile injection equipment rather than the steady access needed to stop HIV transmission.

Harms associated with drug use proceed as much from restrictive policies as from a scarcity of sterile needles. Mass incarceration of drug users, violations of

confidentiality, and frankly discriminatory health policies such as registration of drug users are common to many countries in the region. Practices that bar drug users from services or force them into high-risk environments are found even where people living with HIV or drug users enjoy legal guarantees of equal access or fair treatment.

The following pages focus on developments in the countries of the Commonwealth of Independent States where IDUs are a majority of HIV cases and where IHRD and local partners worked most extensively in 2005.

## Central Asia

HIV prevalence currently is relatively low in the Central Asian states of Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan. However, high rates of injecting drug use and proximity to Afghanistan, where three-quarters of the world's opium poppies are grown, have placed all five countries on the cusp of major epidemics. Government responses to the threat have varied considerably, from refusal of international assistance (Turkmenistan) to bold attempts to implement and expand a wide range of harm reduction services, including substitution treatment and needle exchange in prison (Kyrgyzstan). Strengthening and expanding services remains a priority for harm reduction advocates. Substitution treatment, for example, in 2005 was available only in Kyrgyzstan.

With the exception of Turkmenistan, the region's governments have welcomed assistance for drug and HIV control from abroad, including Global Fund grants and support from the United Nations and donor countries such as the United States, the United Kingdom, Japan, Switzerland, Germany, the Netherlands, and Canada. Portions of Global Fund grants to Kazakhstan, Kyrgyzstan, Tajikistan, and Uzbekistan are allocated specifically for needle exchange. Additional funds for harm reduction have been promised to all the Central Asian republics except Turkmenistan through a \$27 million Regional AIDS Control project launched in November 2005 and funded by the World Bank. Britain's Department for International Development has committed £6.4 million (\$11 million) in assistance over a four-year period, through 2008, to support national HIV programs (including an increase in harm reduction services) in Kyrgyzstan, Tajikistan, and Uzbekistan. USAID has committed \$16.5 million for drug demand reduction, including support

for HIV prevention education, and an additional \$13 million for a project to build HIV/AIDS capacity in the region. Other bilateral funders, including the Japan International Cooperation Agency and the Swiss Agency for Development and Cooperation, have also supported HIV programs in Central Asia.

While some of these initiatives promise great increases in harm reduction efforts, there are wide differences in the number and kind of restrictions placed on the use of these grants. U.S. funds, for example, cannot be used to purchase needles. Although substantial international funding now goes to Central Asian governments and large international NGOs, significant questions remain about whether there is any mechanism to coordinate activities, prevent duplication, or ensure that local NGOs with the strongest ability to reach IDUs have the funds and freedom necessary to work effectively. The Uzbek government's crackdown on NGOs, for example, has chilled harm reduction activities in that country.





Physician examining the abscess of a harm reduction client, Bishkek, Kyrgyzstan

## Kazakhstan

A \$22 million Global Fund agreement was at the center of harm reduction developments in 2005. The grant is meant to enable needle exchange efforts to reach 35,000 people, about 20 percent of the estimated 174,000 IDUs in the country. At the same time, drug users and outreach workers themselves report difficulty in delivering needed services, particularly through community-based needle exchange programs that have yet to receive adequate support. With needle exchange funds going instead to government-sponsored AIDS centers, the government has used Global Fund support to consolidate control of harm reduction, shutting out the network of NGOs that had operated with funding from OSI, USAID, and other donors. Community-based NGOs often reach users unable or unwilling to go to government-affiliated programs.

The grant has also not resulted in methadone availability. Though the Kazakhstan government promised in the Global Fund agreement to deliver methadone to 100 IDUs by the end of 2005, the Ministry of Health sought in February to remove the approach from its grant obligations. “Having studied the experience of other countries on introduction of substitution therapy for drug users,” the Ministry of Health wrote to the Global Fund, “[our] experts have come to the conclusion that it is inexpedient to utilize this therapy on the territory of Kazakhstan.” After negotiations with the Fund, and briefings by international experts, Kazakhstan scaled back plans for methadone rather than scrapping them completely.

High-level political involvement opened the door a bit wider for substitution treatment in late 2005. During a September visit

to Kazakhstan, former U.S. President Bill Clinton mentioned to Kazakh President Nursultan Nazarbayev that methadone was both effective and widely used in the United States. Shortly thereafter, Nazarbayev conveyed his enthusiasm to the Ministry of Health and the Ministry of the Interior, which are now supportive of pilot projects in the cities of Pavlodar and Karaganda. Some 75 patients are expected to enroll in 2006.

## Kyrgyzstan

Kyrgyzstan remains the Central Asian republic with the greatest range of harm reduction services for IDUs, with both needle exchange and methadone available (albeit still in limited quantities), and several projects that offer both drug-free rehabilitation and needle and syringe exchange. Seven years after Kyrgyzstan struck down a law that criminalized drug use, government officials, NGOs, and international experts in late 2005 gathered to review penalties for drug possession with an eye toward their revision. Parliament also approved a new law on HIV/AIDS in June 2005 that guaranteed the confidentiality of HIV-related personal data, decreed that HIV tests must be voluntary, prohibited discrimination against people living with HIV, and guaranteed equal access to medical care for HIV-positive individuals.

Originally funded by IHRD, the Soros Foundation–Kyrgyzstan, and the United Nations Development Programme (UNDP), harm reduction services are now supported by bilateral aid and by a Global Fund grant. According to a Global Fund assessment report from October 2005, a total of 12 “trust points” for needle exchange had been established at NGOs and government AIDS centers across the country. While programs use various approaches, their overall scope remains limited, reaching about a third of IDUs. By November, a combined total

of nearly 85 individuals were also in methadone treatment programs at two projects, one in the capital city of Bishkek and the other in the southern city of Osh.

Kyrgyzstan was also one of the few resource-constrained countries where needle exchange was available in prisons in 2005. As of October, 11 prison colonies, housing about one-third of Kyrgyzstan’s prisoners, had harm reduction programs. The Ministry of Justice has agreed to expand this program to all prisons, as well as to implement methadone treatment in prisons. The ousting of Kyrgyzstan’s president in March 2005, the July 2005 elections that resulted in a victory for his replacement, Kurmanbek Bakiev, and subsequent power struggles have brought multiple changes in government officials and slowed progress toward these goals.

## Tajikistan

Despite severe economic constraints and a long, mountainous border with Afghanistan, Tajikistan has a number of programs offering creative responses to the problems of HIV and opiate use. In Dushanbe, the NGO Ran, which combines service provision and policy analysis, participated in a successful effort to reduce criminal penalties and overcrowding in Tajik prisons. Volunteer, a program in the Pamir mountain region adjoining Afghanistan, offers both needle exchange and abstinence-based treatment. The NGO Dina, in the city of Khojand, offers a comprehensive approach including a drop-in center for drug users, needle exchange, drug-free treatment and trainings, and support for street children. The Canadian International Development Agency, IHRD and the Open Society Institute Assistance Foundation–Tajikistan (OSIAF), contributed to the strengthening of the Tajik Harm Reduction Association in 2005.

## HIV and IDUs in Select Central Asian Countries, December 2005

	Total population	Total registered HIV cases	Estimated number of IDUs	IDUs as share of total registered HIV cases
Kazakhstan	14.8 million	5,440	174,000	76.7%
Kyrgyzstan	5.26 million	807	21,000	77.8%
Tajikistan	6.5 million	506	53,000	70%
Uzbekistan	26.6 million	7,757	87,000	64%*

\* "Parenteral" infections, including IDU and other blood-borne cases

Estimates of HIV cases and number of IDUs vary sharply, and are frequently higher than those provided by national governments.

**Sources:** Population: UN Dept. of Economic and Social Affairs, 2005. IDUs: UNODC HIV/AIDS Unit, September 2005 (midpoint estimates). HIV: Republican AIDS Centers, December 2005. Data for Turkmenistan unavailable.

Many harm reduction projects in Tajikistan expected support from a two-year Global Fund grant of \$2.5 million that began in January 2005 and focused on provision of HIV prevention among IDUs and other vulnerable populations, including sex workers and migrants. Delays related to disbursement and capacity at the local level, however, hampered work. As in other Central Asian republics, the Global Fund has supported mostly government, rather than nongovernmental, harm reduction entities: The grant's principal recipient, UNDP, has created a network of 11 harm reduction programs, many in government-run AIDS centers. These programs were serving an estimated 1,000 clients by the end of the year, half the number reached by seven harm reduction projects funded primarily by OSIAF. After months of negotiations, UNDP and OSIAF reached an agreement in October 2005 to collaborate more closely to ensure quality and effectiveness.

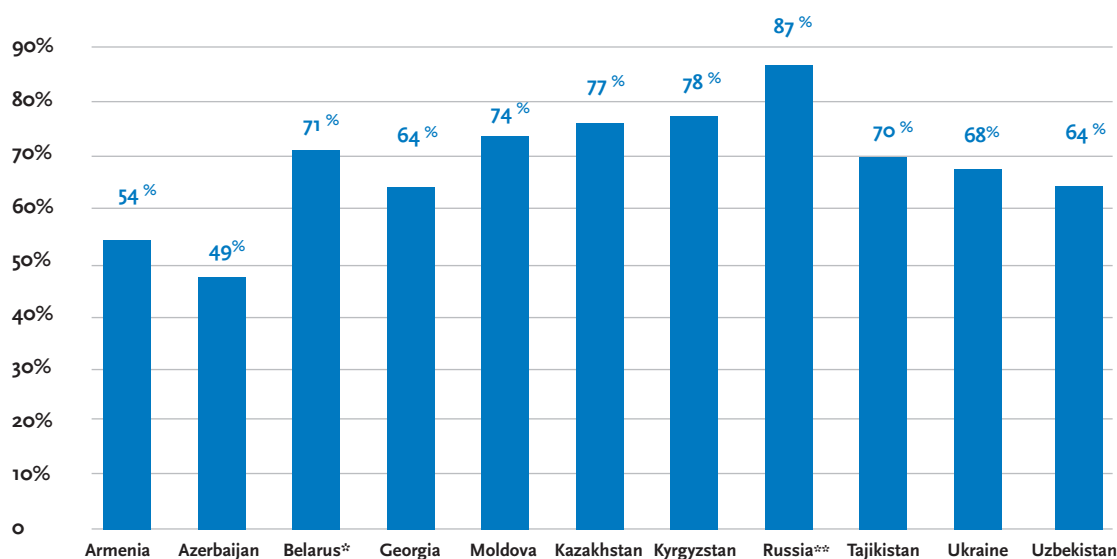
While the nation's drug control agency officially supports needle exchange, IDUs continue to report incidents of bribery and extortion on the part of local police. There is no substitution treatment in the country. Needle exchange in prison, while informally supported by some government officials, is also unavailable.

### Uzbekistan

On paper, Uzbekistan has a strong commitment to syringe exchange, endorsing the creation of 221 "trust points" for needle exchange at narcological dispensaries and AIDS centers. Government funding for these activities, however, has not been forthcoming: as of December 2005, virtually all trust points lacked needles, trained personnel, or both. Uzbekistan forced the few NGOs that were providing syringe exchange with international funding to re-register with the government in 2004. The government also forced the closure of the OSI



### IDUs as Percent of Total Registered HIV Cases CIS Countries, December 2005



\* Data as of September 2005

\*\* Data as of December 2004 (more recent data unavailable)

Sources: National/Republican AIDS Centers, WHO (Belarus). Data for Turkmenistan unavailable.

foundation in Uzbekistan that had been a principal supporter of harm reduction. Other international NGOs providing support for harm reduction have faced restrictions on their activities, and many local NGOs have shut their doors. The Andijon massacre in May 2005, when government forces killed hundreds of protesters, further strained relations between the government and international donors.

A \$4.76 million, two-year Global Fund grant to Uzbekistan, which began in December 2004, is supposed to offer support for harm reduction training, purchase of needles and syringes, and pilot substitution treatment. Here, too, the gap between paper and reality is large. Plans for pilot

substitution treatment, including the import of limited quantities of methadone and buprenorphine, were finalized in 2005, with treatment of 100 patients on buprenorphine and 25 on methadone expected to begin in 2006. Only patients with AIDS who qualify for ARV will be eligible. No Global Fund-supported needles and syringes had been distributed among IDUs, according to a report to the Global Fund in September. UNDP officials have limited their engagement with needle exchange to trainings and have removed needle exchange from the list of indicators used to gauge success, a move that the few NGOs remaining in Uzbekistan are in little position to protest.

## Georgia

A total of five needle exchange projects were operating in Georgia as of October 2005. The Global Fund supported four of the projects, and the Open Society Georgia Foundation funded the fifth. The projects served a total of about 800 clients, and approximately twice that number received legal and social assistance. Substitution treatment with methadone, due to begin in May 2005 under the terms of a Global Fund grant, was delayed following complaints from key Georgian legislators and the unwillingness of several domestic pharmaceutical companies to import the drug.

In October, the grant's principal recipient, the Georgia Health and Social Projects Implementation Center, purchased an initial methadone supply from an Italian company, and in December the first eight patients received treatment at the Institute of Drug Addiction. Though harm reduction advocates were engaged in negotiations with the Ministry of Justice to establish a pilot needle exchange program in prison in 2005, no concrete steps had been taken by the end of the year.

Drug policy, too, remains a challenge in Georgia, one of the few countries in the CIS where the status of drug user is still criminalized. Support from the Canadian International Development Agency and IHRD helped the NGO Alternative Georgia to examine possibilities for drug policy reform in 2005. In October, the Open Society Georgia Foundation and the Ministry of Health joined the NGO to convene an international conference on the subject.

### Georgia, HIV, and IDUs

1) Total population	4.47 million
2) Estimated number of IDUs	12,000
3) Total registered HIV cases	880
4) IDUs as share of total registered HIV cases	64%

*Estimates of HIV cases and number of IDUs vary sharply, and are frequently higher than those provided by national governments.*

**Sources:** 1) UN Dept. of Economic and Social Affairs, 2005; 2) UNODC HIV/AIDS Unit, September 2005 (midpoint estimate); 3) National AIDS Center, December 2005; 4) National AIDS Center, December 2005

## Russia

With an epidemic concentrated among young IDUs and an economy boosted by rising oil prices in 2005, one would expect harm reduction programs in Russia to have expanded sharply. In fact, programs to reach IDUs with HIV prevention remained strikingly limited.

Substitution treatment of any kind for drug addiction is illegal. HIV has been detected in 82 of Russia's 89 oblasts (regions). Needle exchange projects operate in only 33 oblasts, and then often at levels far below the coverage needed to achieve lasting results. In Moscow, where the largest number of Russians with HIV resides, there is no needle exchange program. Many programs, begun with grants from donors such as OSI, DFID, Médecins du Monde, the Ford Foundation, and the Open Health Institute, have been disappointed in their hopes of support from the government. By 2005, the national government still offered no financial backing for needle exchange. Regional authorities supported programs through in-kind donations, small grants, or sponsorship of needle exchange at government clinics, though NGO programs frequently received no government funding at all.

### Shortfalls in International Funding

Russian harm reduction programs have looked to international funding to make up the gap. The fact of increased foreign assistance for HIV in Russia, however, has not meant mechanisms to ensure that those at greatest risk—IDUs, sex workers, and sexual partners of drug users—are reached. In 2005, for example, more than two years after signing a World Bank loan for \$150 million for TB and AIDS, the government had yet to deliver substantial support to a single harm reduction project. Russia's first Global Fund grant, awarded in 2004 to a consortium of NGOs in a project known as GLOBUS, supports 23 needle exchange projects in 10 oblasts, and in 2005 offered some additional support for harm reduction projects through grants to the Russian Harm Reduction Network (RHRN). No funding for programs outside the 10 oblasts

### Russia, HIV, and IDUs

1) Total population	143 million
2) Estimated number of IDUs	1.98 million
3) Total registered HIV cases	333,332
4) IDUs as share of total registered HIV cases	87%*

\* Data as of December 2004 (more recent data unavailable)

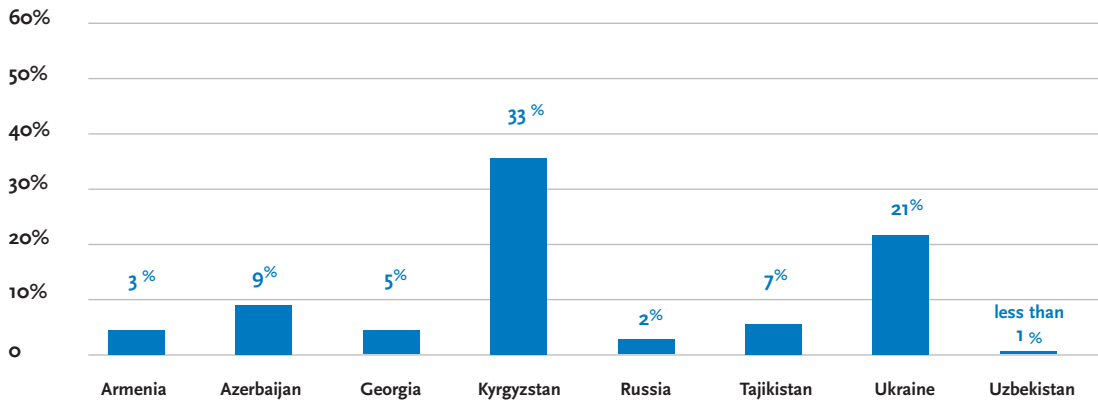
Estimates of HIV cases and number of IDUs vary sharply, and are frequently higher than those provided by national governments.

Sources: 1) UN Dept. of Economic and Social Affairs, 2005; 2) UNODC HIV/AIDS Unit, September 2005 (midpoint estimate); 3) Federal Aids Center, December 2005;

4) Federal AIDS Center, December 2004

## Percent of IDUs Reached by Needle/Syringe Exchange Programs

### Select CIS Countries, December 2005



Note: UNAIDS recommends 60% coverage for effective HIV prevention among IDUs

Sources: IDU Estimates: UNODC HIV/AIDS unit, September 2005 (midpoint estimates, data collected 2002-2005); WHO/UNAIDS October 2005 (Ukraine)

Coverage Estimates: Open Society Institute/ Soros Foundation network (Armenia, Azerbaijan, Georgia, Kyrgyzstan, Tajikistan); Russian Harm Reduction Network; HIV/AIDS Alliance (Ukraine); GFATM and program reports (Uzbekistan).

is expected for 2006. A second Global Fund grant, made to a government-controlled entity, focuses on HIV treatment rather than prevention. Many bilateral funders have shifted emphasis to HIV projects that enjoy greater government approval.

Overall, a 2005 survey of 38 cities found that despite the sharp increases in overall funds for HIV programs from abroad, there was nearly 30 percent less funding for harm reduction programs than in 2004.

### Drug Policies that Fuel HIV Infection

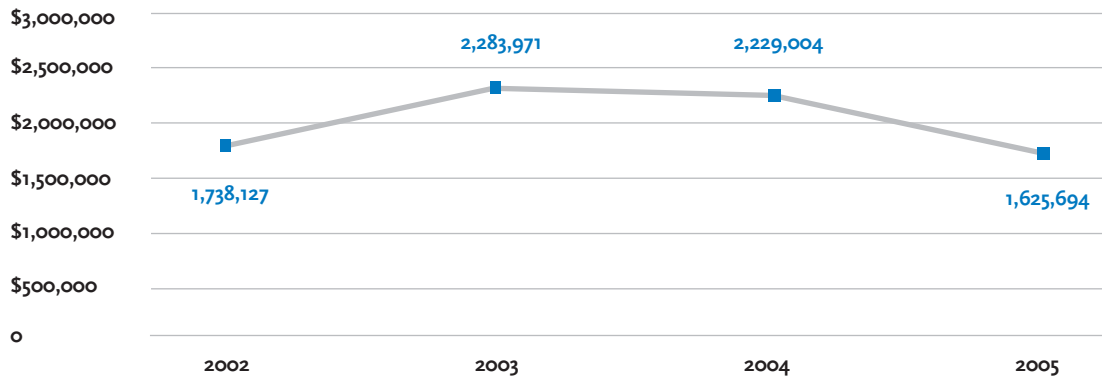
In 1998, a tightening of Russian drug laws made possession of illicit drugs—including the residue in a used syringe—punishable by imprisonment. One hundred thousand Russians were convicted in the first year

following passage of the new penalties, and the number of those jailed for drug offenses increased five-fold between 1997 and 2000. As in other penal systems (see *Prisons, HIV, and IDUs*, page 55), mass incarceration meant accelerated HIV infections.

The Russian government in 2004 revised the penal code so that possession of small amounts of drugs (“less than 10 average single doses”) resulted in an administrative rather than a criminal offense. Following the reform, some 32,000 people were released from prison or had their sentences shortened. The Federal Office for Drug Control and Trafficking had bitterly opposed the 2004 penal code changes, claiming that they undermined law and order. In April 2005, under heavy lobbying from the Office for Drug Control, State

## Funding for Harm Reduction Programs in Russia, 2002–2005

*Decrease of 27% in funding since 2004*



*Source:* Russian Harm Reduction Network, 38-city survey, July 2005.

Duma members considered repeal of key provisions of the 2004 reforms, including the removal of “average single dose” terminology from the penal code. The proposed new law, which had its third and final hearing on December 21, 2005, will set fixed doses and penalties for mandatory imprisonment. While these will be determined in 2006, AIDS advocates fear that imprisonment will once again be the penalty for possession of even small amounts of heroin or marijuana.

Needle exchange projects also faced policy challenges. Since 2003, Russian drug control authorities have suggested that needle exchange programs are in violation of laws prohibiting promotion of drug use. While those claims have been countered by expressions of support by the Ministry of Health and amendments to the criminal code that authorize the operations of “approved” needle exchange programs,

many programs are operating in legal limbo. A government order clarifying official guidelines for syringe exchange, promised in 2005, has yet to be issued. Early drafts of this order called for an end to needle exchange by peer outreach workers, a key component for successful programs in a country where many drug users hesitate to visit central locations for fear of shakedowns by the police or the addition of their names to lists kept by government authorities.

### Promising Signs: New Global Fund Grant and New Commitment from President Putin

In June 2005, a group of NGOs, including RHRN and the Russian Community of People Living with HIV/AIDS, applied for a Global Fund grant specifically for support and expansion of harm reduction projects. The application sought \$10 million over five



Outreach workers in Volgograd, Russia

years to increase the availability of clean needles and condoms in Russian regions not covered by the two earlier grants. The government-controlled country coordinating mechanism (CCM) for the Global Fund, which included a high-ranking official at the Ministry of Health, the president of the Russian Academy of Medical Sciences, and the head of the Federal AIDS Center, opposed the application, claiming it violated protocols and was unnecessary.

After documenting a pattern of irregular and potentially discriminatory treatment by the CCM, however, the NGOs were successful in seeking consideration for Global Fund support independent of the country coordinating mechanism. In December, RHRN received word that the grant would be awarded so long as the Global Fund could meet its own fundraising goals. If awarded, the grant will mark the single largest financial contribution for needle exchange in Russian

history, and a significant achievement for Russian civil society.

Federal government commitment to HIV treatment is also increasing. In September, President Putin announced that Russia would allocate up to 3 billion rubles (about \$106 million) to fight HIV/AIDS in 2006, an amount 20 times higher than that provided by the 2005 budget. While declining to call HIV an “epidemic,” Putin noted the importance of providing HIV treatment for all in need, and Ministry of Health officials have sought input from NGOs and UN agencies in determining spending priorities. At the close of 2005, however, Putin was proposing heightened restrictions on NGOs working on human rights and political reform, new restrictions on foreign NGOs, and mandatory disclosure by Russian organizations and individuals of sources of foreign support.

# voices from the front

## **ITPC FINDS GAPS IN TREATMENT PREPAREDNESS IN RUSSIA**

*The International Treatment Preparedness Coalition (ITPC), a global coalition of HIV treatment activists, selected Russia as one of eight countries for evaluation in 2005. In November, using an analysis prepared by people living with HIV in Russia, ITPC issued its report, Missing the Target, and noted that only about 3,000 of the estimated 50,000 Russians in need of ARV were receiving treatment. Obstacles noted by the report's authors included:*

### **HIV drug pricing and regulations.**

Generic ARV was unavailable in Russia in 2005, and medications were purchased through regional tenders rather than through a centralized mechanism. Though prices for a year's supply of first-line combination therapy fell from \$12,000 to as low as \$1,200 as a result of Global Fund agreements, medications were still prohibitively expensive. ARV purchased through government tenders cost as much as \$8,000 per patient per year.

### **AIDS care infrastructure.**

HIV treatment remained "siloed" in AIDS centers that were separated from the rest of the Russian health care system, a fact that limited referrals, coordination of care, and engagement by a range of Russian health professionals.

### **Stigma and lack of support for treatment uptake and adherence.**

Hostility or indifference to patients with HIV, and lack of efforts to educate patients about availability of HIV treatment or to help them stick to demanding treatment regimens, meant many missed out on the benefits of treatment.

### **Separation of HIV and TB services.**

TB is the most common killer of people with HIV in Russia, yet TB and AIDS services in Russia were not integrated in 2005. Many TB and HIV clinics referred patients back and forth, bouncing them between physicians without providing them critically needed treatment.

*For the full text of the report, go to [www.aidstreatmentaccess.org](http://www.aidstreatmentaccess.org).*



## Ukraine

The first country in the former Soviet Union to experience a widespread HIV outbreak, Ukraine is rightly cited as a regional leader in harm reduction and HIV treatment. Laws protect those with HIV from discrimination, the country has a well-established and highly organized network of people living with HIV, and a Global Fund grant has allowed syringe exchange programs to grow from a handful supported by private foundations to more than 250 projects reaching an estimated 70,000 IDUs across the country.

Several projects combine Global Fund monies, government support, and grants from private foundations to offer 12-step (abstinence-based) programs, needle exchange, HIV treatment education, and support groups for people who use drugs all under the same roof. Support from IHRD, the Canadian International Development Agency, and the International Renaissance Foundation, among other funders, helped Ukrainian advocates integrate HIV prevention organizations into important political structures, and to press for key policy reforms in 2005.

Methadone is not currently available for substitution treatment, but buprenorphine is. In September, again with support from the Global Fund, Ukraine expanded pilot buprenorphine projects to offer the medication to people also on ARV treatment in seven regions. By the end of December 2005, there were 165 people receiving buprenorphine substitution treatment in Ukraine, and plans called for scale up to 7,000 patients by the end of 2008. The International HIV/AIDS Alliance and WHO Ukraine have been key partners in pressing for quality and availability of the treatment.

Support from IHRD and the International Renaissance Foundation also allowed the launch in September of a complementary project to improve ARV

treatment for IDUs by increasing collaboration between providers of harm reduction, substitution treatment, and HIV treatment services. Activists were at the forefront of efforts to make this a priority, playing a prominent role at a training held in Nikolayev where providers of ARV, buprenorphine, and needle exchange learned about patient case management and measures to increase adherence to ARV.

ARV treatment became part of the presidential agenda in November, when Ukrainian President Viktor Yushchenko, his staff, and representatives of the All-Ukrainian Network of PLWHA held discussions on what activists alleged was a nontransparent government ARV procurement process that inflated prices. At the end of the month, Yushchenko issued a special executive order calling for the establishment of a new National Coordination Council on HIV/AIDS; strengthening regional AIDS centers; and announcing that the health minister would sign an agreement with the Clinton Foundation HIV/AIDS Initiative. According to that agreement, the foundation will assist the Ukrainian government in procuring ARV and opiate substitution treatments, establishing a training and mentoring program for HIV clinicians, and increasing access to HIV care and treatment programs.

## Ukraine, HIV, and IDUs

1) Total population	46.5 million
2) Estimated number of IDUs	397,000
3) Total registered HIV cases	86,839
4) IDUs as share of total registered HIV cases	67.8%

*Estimates of HIV cases and number of IDUs vary sharply, and are frequently higher than those provided by national governments.*

**Sources:** 1) UN Dept. of Economic and Social Affairs, 2005; 2) UNODC HIV/AIDS Unit, September 2005 (midpoint estimate); 3) Ukrainian AIDS Center, December 2005; 4) Ukrainian AIDS Center, December 2005

### Restrictive Drug Policy Proposals

Despite a long history of successful AIDS activism in Ukraine, policy battles are ongoing. In June 2005, advocacy efforts by harm reduction and PLWHA activists helped block an attempt by the Ministry of Health's Drug Control Committee to reclassify methadone and place it on a list of drugs considered "illegal substances for use in any medical practice," a move that would have made future implementation of the treatment extremely difficult.

After losing the battle on reclassifying methadone, the Drug Control Committee proposed changes that would have reduced the amount of acetylated opium and home-made preparations of opium that would subject individuals to possible prison sentences. Under Ukrainian law, acetylated opium, one of the most widely used drugs in Ukraine, is punishable by imprisonment when the amount possessed is 0.1 gram or more. The proposed reform would have lowered the amount punishable to 0.002 gram—a level far below the average single dose used on the street. The draft also contained language that would criminalize the possession of all parts of poppies, from the whole

plant to specific extracts, regardless of opium alkaloid content.

The Drug Control Committee said that its goal with the resolution was to assist prosecutors and courts by creating an objective standard. International and local NGOs pointed out, however, that strict compliance with the new standards would mandate detention of thousands of drug users, thus further straining the nation's overcrowded and unsafe prisons. Those expressing concern included Human Rights Watch, the International HIV/AIDS Alliance, the International Renaissance Foundation, the International Centre for Policy Studies, the All-Ukrainian Council for Patient Rights and Protection, the Ukrainian Harm Reduction Association, and OSI.

In July 2005, activists sent an open letter to key government officials noting that the proposed change "ignores the fact that over 65 % of the individuals arrested under illicit drug charges are only found in possession of drugs, and usually have no intention to sell them." In other words, the advocates noted, "persons most frequently prosecuted for drug 'trafficking' are in fact merely drug users themselves."

# country briefs

## EASTERN EUROPE AND THE FORMER SOVIET UNION

### Armenia

In Armenia, where IDUs accounted for 54 percent of all registered HIV cases as of December 2005, fewer than 2 percent of IDUs are reached by needle exchange services. In 2005, however, officials secured support from the Global Fund to build a bold new initiative: HIV prevention education and needle exchange in prisons. As of November 2005, a total of 14 programs offered HIV prevention services to IDUs in prisons, with three of them offering needle exchange. Two more prison needle exchange programs were expected to be operational by June 2006.

### Azerbaijan

A two-year, \$6.1 million Global Fund grant received in 2005 will give harm reduction a major boost in Azerbaijan, where IDUs were 49 percent of all HIV cases as of December and where only 1,750 were being reached by needle exchange. Grant targets include reaching 12,500 IDUs with needle exchange services, and increasing the number of those receiving methadone from the 80 currently on treatment to 500 by June 2007.

### Belarus

Political crackdowns have severely constrained NGO activities in Belarus, where 71 percent of cumulative HIV cases as of September 2005 were among IDUs. Global Fund support, however, has allowed

expansion of harm reduction services to an estimated 3,450 IDUs, more than two-thirds of the end-of-year target of 5,000. Methadone, though promised in the Global Fund grant application, remains unavailable, with the Ministry of Health delaying registration of the medicine or its endorsement. A pilot program for next year will make the medication available only for those with AIDS, as a support for ARV treatment.

### Lithuania

Harm reduction came under sustained attack in 2005 in Lithuania, where IDUs as of December comprised 79 percent of all HIV cases. A campaign against methadone and the local Soros foundation that had been an early supporter of the treatment included calls for investigation of all Soros-funded entities, sharp criticism in the media, and demands by a commission on drugs in the Lithuanian parliament to close the country's methadone programs entirely. The health minister, representatives of the World Health Organization, and a local coalition of advocates, service providers, and patients mobilized successfully to correct misinformation and emphasize the harmony of Lithuanian approaches with international evidence and the European Union drugs strategy. At the close of the year, however, negative publicity and calls for special investigations continued.

### Moldova

Moldova, where IDUs were 74 percent of all registered HIV cases in December 2005, was the first CIS country to implement needle exchange in prisons. In 2005, it also became the first to make methadone maintenance treatment available in penal institutions (*see Prisons, HIV, and IDUs, page 55*). More generally, HIV grants totaling more than \$2.4 million from the Global Fund, the Swedish International Development Agency, and the World Bank allowed expansion of harm reduction to vulnerable groups, including IDUs and sex workers, through 16 projects nationwide.

### Poland

In Poland, where 54 percent of total HIV cases were among IDUs as of December, a proposal by the Polish Ministry of Health to decriminalize possession of drugs for personal use foundered in 2005 despite support from leading human rights and HIV organizations. On the positive side, new regulations lowered to 18 the age of those able to receive methadone, and authorized NGOs licensed by the government, rather than only government clinics, to dispense the medication. Human rights and HIV advocates hope the change will allow for expansion of Polish methadone programs, which for years have served fewer than 1,000 patients despite great demand.



Worker preparing materials for outreach to drug users, Teheran, Iran

# Harm Reduction Developments: Asia

HIV epidemiologists increasingly refer to what they call the “second wave” countries of Asia, places where rates of HIV and the numbers of those infected could lead to AIDS epidemics as potentially widespread and devastating as those experienced in sub-Saharan Africa.

Even without generalized HIV epidemics, the populations of countries like China, India, and Indonesia, home to 40 percent of all people in the world, mean that even relatively low HIV prevalence results in enormous numbers of people living with HIV. In India, where UNAIDS estimates nearly 1 percent adult HIV prevalence and as many as 8 million total infections, there are already more people with HIV than in any other country in the world.

The fact that HIV infections are frequently concentrated among different groups in different regions of a single country make it difficult to define what is meant by “injection-driven” epidemics. In Burma, for example, though the majority of officially registered cases are not among drug users, an IDU-driven epidemic is exploding in the eastern and southern regions,

especially along the border with China and Thailand. Injecting drug use accounts for the majority of HIV infections in much of northeastern India, notably the states of Manipur and Nagaland. Afghanistan, Cambodia, and Pakistan are all countries where the majority of HIV infections are sexually transmitted, but where injection-driven epidemics are growing rapidly and must be addressed.

Harm reduction advances, though spreading less quickly than HIV, were marked in Asia in 2005. As elsewhere in the report, this section does not represent anything approaching a comprehensive survey of harm reduction needs or advances in Asia in 2005. Instead it offers a snapshot of some key countries with injection-driven epidemics where IHRD engaged with international and local partners during the year.



## China

Those looking for examples of national harm reduction leadership and authoritarian state control of drug users found both in China in 2005. The five-year plan released by the Chinese government in June identified the HIV epidemic as a priority public health concern, further energizing the “four frees and one care” campaign (free antiretroviral drugs for poor people in urban areas and everyone in rural areas; free voluntary counseling and testing; free counseling and treatment for pregnant women; free schooling for children orphaned by HIV/AIDS; and economic assistance to families affected by HIV/AIDS) launched by the government in December 2003.

While not an absolute majority of HIV cases in China, IDUs represented an estimated 44 percent of all those infected as of December 2005—the largest share of a national epidemic that also included individuals infected via blood collection practices or sexual transmission. Nearly 90 percent of all registered cases of HIV among IDUs were concentrated in seven provinces. Chinese national guidelines, adopted in 2004, urge the promotion of substitution therapy and needle exchange as primary HIV prevention strategies for IDUs.

Further, the Chinese government has pledged to nearly double overall spending on HIV prevention, to some \$185 million, between 2005 and 2007. In July 2005, the Chinese Center for Disease Control and Prevention received the first disbursement of a two-year Global Fund grant totaling \$24 million to support HIV prevention and treatment among IDUs and sex workers in

seven hard-hit provinces. Total Global Fund support for this effort to reach drug users and sex workers is expected to be \$63 million over five years.

Harm reduction projects have grown along with funding and commitments from Beijing. Ninety-one needle exchange projects were established throughout China as of November 2005, and the head of the National Center for AIDS/STD Prevention and Control (NCAIDS), Wu Zunyou, has set a target, with Global Fund support, of providing sterile injection equipment to 105,000 IDUs by 2010. Methadone was being locally manufactured and provided to more than 6,500 patients in 58 maintenance programs by the end of December 2005, with plans to expand substitution treatment to 200,000 patients by 2010.

GFATM assistance will also be used to supplement wider government efforts to provide ARV, supporting delivery of



Anti-drug billboard, Kunming, China

treatment to some 10,000 people with HIV, including IDUs, by the end of 2007. These numbers are insufficient to address an epidemic the size of China's, where even by conservative government estimates at least 650,000 people were thought to be infected with HIV at the end of 2005. Nonetheless, the planned scale-up stands in marked contrast to other countries where substitution treatment programs often do not exist and needle exchange is supported nominally or not at all by central governments.

Chinese commitment to quality of harm reduction programs is less clear. Some officials have confessed little interest in the patient-centered aspects of harm reduction, noting that they favor restricting future needle exchange primarily to rural areas. Methadone, seen as a better form of crime control, is favored for cities. The entry criteria for methadone maintenance

programs in 2005 were extremely restrictive: only those who had been through two institutionalizations in prison-like forced rehabilitation centers (or one residence in forced rehabilitation and another in a forced labor camp) were eligible. Those unable to produce local residence permits were denied access. Police, rather than doctors, often retained final say over whether an individual could enter methadone treatment. If clinic physicians accepted patients without complying with these guidelines, they did so in violation of official policy.

The emphasis on methadone as a tool to increase social control echoed a more general tension in China between the aims of the health officials and campaigns against drug users by the Public Security Bureau (PSB). Sweeps in which alleged drug users were sentenced without trial to compulsory detoxification facilities were

## China, HIV, and IDUs

1) Total population	1.32 billion
2) Estimated number of IDUs	1.93 million
3) Total registered HIV cases	141,241
4) IDUs as share of total registered HIV cases	44.3%

*Note: IDUs represent the largest single share of HIV infections in China.*

*Estimates of HIV cases and number of IDUs vary sharply, and are frequently higher than those provided by national governments.*

**Sources:** 1) UN Dept. of Economic and Social Affairs, 2005; 2) UNODC HIV/AIDS Unit, September 2005 (midpoint estimate); 3) Ministry of Health, UNAIDS and WHO, December 2005; 4) Ministry of Health, UNAIDS and WHO, December 2005

a routine part of the “People’s War on Drugs” declared by the PSB in 2005. In June, the Beijing PSB urged the creation of lists of drug users at the community level, requiring that drug users present themselves for mandatory detoxification, and levying penalties on drug users who failed to submit. The “People’s War” reportedly relies on a system of quotas and bonuses to motivate local police to arrest specific numbers of drug users. Hundreds of new police have been hired in many provinces, and construction of multiple new forced rehabilitation centers is underway. In Yunnan province, for example, the number of beds at such centers is expected to reach 68,000 by the end of 2008, double the number available in 2005. Those drug users who relapse after forced rehabilitation can be sent to “re-education through labor” camps—where inmates perform a two-to three-year sentence of work without pay for up to 15 hours daily on such tasks as assembling dolls or trinkets for the burgeoning tourist industry.

Needle exchange efforts are also seriously constrained by law enforcement.

Reports from northwest China in 2005 documented clashes occurring between AIDS activists identified as former drug users and law enforcement authorities. Needle exchange outreach workers report that they have been followed and arrested, and that police wait near syringe distribution points to detain drug users. If the Chinese Narcotics Control Commission is successful, possession of a syringe may soon be a crime. The commission is also said to be preparing new legislation that will stiffen penalties for drug consumption as well as drug possession.

Even those drug users who gain access to care may find themselves subjected to bizarre and unproven medical interventions. Between 2000 and 2004, Chinese physicians—basing their approach on similar operations in Russia—performed brain surgery on some 500 drug-dependent patients, drilling holes in their heads and inserting heated needles that were clamped in place for days to destroy brain tissue. Halted temporarily by the Ministry of Health, this addiction “treatment” was resumed in China in 2005.

# voices from the front

## PLAYING GOD IN KATHMANDU

*In 1991, Nepal was the first developing country where an NGO established a needle exchange program. Although IDUs made up 21 percent of officially registered cases in 2005, prevalence rates among IDUs in some parts of the country were as high as 70 percent. Rajiv Kafle, coordinator of the Kathmandu HIV advocacy and support organization Navairan Plus, posted the following essay to a listserv in spring 2005. It is reprinted with the author's permission.*

A Danish musician from the 1960s wrote a song about Kathmandu: "The streets are made of rubber—take off your shoes and walk on them." In present day Kathmandu, if you take off your shoes there is a chance that you will get pricked by a needle. Over 70 percent of drug users living in this historic city are infected with HIV. However, this neither rings an alarm for the government nor for the development partners working in Nepal. Our government is silent because it is in denial. The development partners are silent because Kathmandu is neither strategically nor politically important for them. For example, the Global Fund has overtly ignored the challenges it is facing in this country. Some time back a former board member of the fund wrote to me, "Unfortunately Nepal is not a priority for the fund."

Tourists traveling to Nepal in the early 1960s wondered if Kathmandu had more temples than houses where people lived. If so, then it obviously had more gods and goddesses than people. Maybe it was true [then] but not anymore. As far as gods and goddesses, though, in the past few years I have turned into one myself. And it is really a difficult job.

So what are my responsibilities as a god? One of my major roles is to decide who lives and who dies. In the Hindu religion we believe in reincarnation, so it is easier for me to decide who should die now and be reborn and who should continue with their current life. This year I have already permitted a few people to die. Can you believe it?

Recently a guy came to me and asked me for help. He had TB and had been living with HIV for the past several years. He was poor and had no one to look after him. He was weak and weary. I decided to help him out since I had some funds for his basic checkups, for some ARV drugs, if



he needed them, and TB treatment was available for free. I welcomed him to my hospice. He was immediately put on anti-TB treatment and his CD4 was checked. He needed ARVs too. His CD4 count was less than 50.

Now the real challenges began. We only had a nevirapine combination (AZT, 3TC and nevirapine) available to us. We had to find money to put him on an efavirenz combination since he was also on TB medication. Then he showed signs of anemia and we changed his regimen again. Then he started complaining about losing his eyesight. The doctors suggested that it could be CMV or it could be toxoplasmosis. And then it was time for me to decide if he was to live or be left to die. And he is not the only person I am looking after.

I cannot afford to keep him alive.

This is not the world we wanted for people living with HIV. This is not what activists around the globe are fighting for. AIDS has divided this world in two—one for the rich, where clinical trials are underway for a new generation of improved ARV drugs, and one for the poor where people still have to live at the mercy of gods like me.

## Indonesia

The world's most populous Muslim nation, Indonesia is famous for its rigid anti-drug laws, and has made headlines for threats to execute foreign visitors caught with drugs in their luggage. Yet the government of President Susilo Bambang Yudhoyono, who took office in October 2004, surprised observers in 2005 by his public support for new strategies to prevent HIV among IDUs.

Methadone, for example, is not generally available in Indonesia, but nearly 400 patients receive the substitution treatment through special pilot projects in Jakarta and Bali co-sponsored by the World Health Organization (WHO) and the Ministry of Health. Indonesian prison authorities in 2005 also piloted methadone maintenance, opening pilot programs in Bali and Jakarta, with 15 people receiving substitution treatment in Bali's Kerobokan prison by December. A small number of physicians in different regions have been trained and

certified to prescribe buprenorphine as a substitution treatment.

Needle exchange programs operate in a similarly small-scale and legally ambiguous fashion, with officials across Indonesia's 6,000 inhabited islands differing on whether federal law permits or prohibits the approach. In Bali, for example, where the governor is supportive, several NGOs offer needle and syringe exchange and support for IDUs with HIV, as well as programs for drug users who express interest in modifying, reducing, or eliminating their

### Indonesia, HIV, and IDUs

1) Total population	222 million
2) Estimated number of IDUs	580,000
3) Total registered HIV cases	4168
4) IDUs as share of total registered HIV cases	44.1%

*Note: IDUs represent the largest single share of HIV infections in Indonesia.*

*Estimates of HIV cases and number of IDUs vary sharply, and are frequently higher than those provided by national governments.*

**Sources:** 1) World Bank, 2005; 2) UNODC HIV/AIDS Unit, September 2005 (midpoint estimate); 3) Ministry of Health, September 2005;

4) Ministry of Health, September 2005





Harm reduction activist (left) and her team, Jakarta, Indonesia

drug use. One NGO on that island, Yaysan Mata Hati, also works closely with staff at Kerobokan prison to develop peer education and pre-release programs. Another Bali NGO, Yakeba, runs programs for those recently released.

Elsewhere in Indonesia, syringe programs operate in quasi-underground fashion, with needle exchange a rarely discussed component of other outreach efforts to IDUs. By December 2005, some 20 needle exchange programs were operating in five different Indonesian provinces, with several of them housed in community public health centers known as *puskesmas*. Estimates of numbers of those served by such efforts are impossible to obtain. AusAID is the only

donor currently supporting both needle exchange and methadone provision.

The limited scope and longstanding pilot status of both substitution treatment and needle exchange mean that harm reduction is available to only a fraction of Indonesian IDUs. In the past two years, an estimated 80 percent of new HIV cases in the country have been the result of contaminated needles, making the epidemic one of the most concentrated among IDUs outside the former Soviet Union. The epidemic is particularly dire in prisons, where Indonesian authorities operate special facilities for narcotics-related crimes, and in which WHO estimates that as many as 25 percent of inmates are HIV-infected.

## Iran

The Iranian government has demonstrated more openness to harm reduction than most countries in Asia or the former Soviet Union. As in many Asian countries, those convicted of drug trafficking in Iran face stiff sentences, including flogging, imprisonment, or execution. Iranian officials, however, have separated efforts to control drug trafficking from those to help drug users, speaking out in favor of harm reduction at international meetings and providing financial support for substitution treatment and needle exchange.

The first substitution treatment program in Iran was initiated by an NGO, Persepolis, in 1999 in the city of Marvdasht. Using buprenorphine, Persepolis provided treatment to more than 3,000 people dependent on heroin. In 2005, the NGO operated three drop-in centers in Teheran that offered community-based methadone maintenance treatment along with peer counseling, needle exchange, outreach, food, showers, and support for those on ARV. In December 2005, approximately 1,500 people received

methadone from clinics run by Persepolis, the Iranian National Center for Addiction Studies and others, and 2,100 more patients were receiving substitution treatment in prison clinics. Demand still far outstripped supply: Persepolis alone reported a waiting list of as many as 1,500 Iranians hoping for substitution treatment.

Overall levels of needle exchange were difficult to estimate in 2005. Some services were provided by the “triangular clinics” where the Ministry of Health, NGOs, and

### Iran, HIV, and IDUs

1) Total population	69.5 million
2) Estimated number of IDUs	206,000
3) Total registered HIV cases	12,556
4) IDUs as share of total registered HIV cases	62.3%

*Estimates of HIV cases and number of IDUs vary sharply, and are frequently higher than those provided by national governments.*

**Sources:** 1) UN Dept. of Economic and Social Affairs, 2005; 2) UNODC HIV/AIDS Unit, September 2005 (midpoint estimate); 3) Ministry of Health, January 2006; 4) Ministry of Health, January 2006



En route to outreach, Teheran, Iran

community-based groups collaborate to offer health services to IDUs and PLWHA. The clinics generally provided condoms, bleach to sterilize needles, and ARV and TB treatment for those in need—although their locations in city hospitals or health centers made them difficult to access for some drug users and an unlikely site for exchange of large numbers of syringes. Approximately 70 “triangular clinics” were in operation in Iranian communities in 2005, with an additional 50 clinics in prisons offering methadone maintenance and health services.

Prison harm reduction services are a particularly high priority, since an estimated half of the nation’s 130,000 prisoners have been charged with drug offenses, one-fifth are estimated to be IDUs, and perhaps a

quarter of incarcerated IDUs are HIV-positive. Two pilot needle exchange programs began in Iranian prisons in 2005, though needles will not actually be provided to prisoners until 2006.

While harm reduction services were once regarded as illegal, officials have explicitly indicated that the programs benefit society and should not be impeded. In January 2005, the head of the Iranian judiciary, Ayatollah Seyed Mahmood Hashemi Sharoudi, issued an executive order to “remind judges at all courts of justice and prosecutors’ offices” that provision of sterile injection equipment and methadone maintenance treatment are “motivated by... protecting society from the spread of deadly contagious illnesses.” The order concluded

# voices from the front

## **HEAD OF IRANIAN JUDICIARY URGES PROSECUTORS NOT TO IMPEDE HARM REDUCTION**

January 24, 2005

Ref: I-83-14434

ISLAMIC REPUBLIC OF IRAN

Judicial Branch

Executive Order to All Judicial Authorities Nationwide

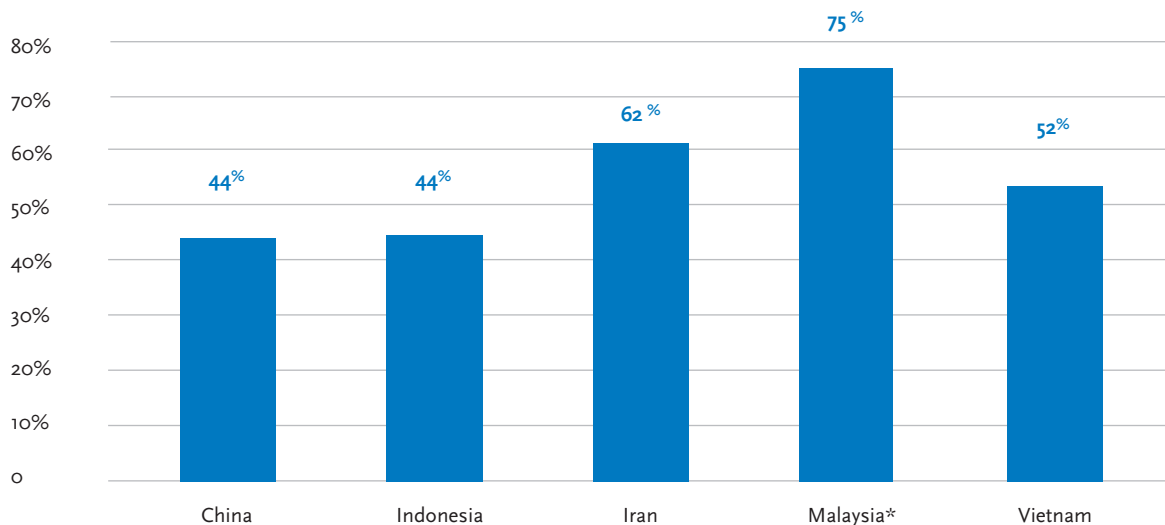
The legal obligations of the Ministry of Health and Medical Education include the implementation of programs necessary for the prevention of transmission of communicable diseases that promote harm reduction and the maintenance of public health and well-being of society... Interventions that have been supported by the Ministry of Health and Medical Education include provision of needles, syringes, and other materials used by drug addicts and AIDS patients, as well as methadone maintenance treatment programs as a means of combating HIV and hepatitis infections among those addicted to drugs.

According to the Ministry, some judicial authorities have regarded such interventions as the abetting of crime, and so subject to punitive action... [This attitude is] unintentionally impeding the implementation of health and treatment programs aimed at preventing and combating the transmission of dangerous contagious diseases.

Therefore, this is to remind judges at all courts of justice and prosecutors' offices throughout the country that since a major element of abetting crime is verification of malicious intent, the said interventions are clearly void of such malicious intent and rather motivated by the will to fulfill the mission of protecting society from the spread of deadly contagious diseases such as AIDS and hepatitis. Judicial authorities should... not unfairly characterize service providers as facilitating criminal abuse of narcotics, and must not impede the implementation of such needed and fruitful programs.

*Ayatollah Seyed Mahmood Hashemi Sharoudi*  
*Head of the Judiciary*

### IDUs as Percent of Total Registered HIV Cases Select Asian Countries, 2005



\* Data as of December 2004 (more recent data unavailable)

Note: IDUs represent largest share of HIV cases of known origin in both China and Indonesia.

Sources: China Ministry of Health / UNAIDS / WHO, January 2006; Indonesia Ministry of Health, September 2005; Iran Ministry of Health, January 2006; University of Malaya Medical Center, December 2004; Vietnam Ministry of Health/National Institute for Hygiene and Epidemiology, November 2005

with the hope that law enforcement would not impede the work of these “needed and fruitful programs.” (see page 42)

Mahmoud Ahmadinejad, the surprise victor in Iran’s June 2005 presidential elections, took office in August. Despite a reputation for social conservatism, he also brings a history of support for harm reduction, having issued an order authorizing 40 methadone programs as mayor of Teheran. Although that order was not fulfilled, the Ahmadinejad government has shown no signs of retreat from public support for harm reduction. In September 2005, the Ministry of Health asked the World Health Organization (WHO) to review existing harm reduction efforts among IDUs

nationwide, and to provide recommendations for further expansion of Iranian harm reduction efforts. On December 1, World AIDS Day, Deputy Health Minister Moayyed Alavian announced that the ministry was determined to sharply scale up activities to ensure that 50 percent of Iran’s IDUs, rather than the 5 percent currently reached, would have access to harm reduction services. Emphasizing collaboration with civil society, Alavian noted that the prevalence of HIV and hepatitis C among IDUs made it clear that all available resources must be focused on cost-effective, evidence-based interventions that had been shown to slow transmission of blood-borne illnesses in other parts of the world.



# Malaysia

Malaysia, where the 1952 Dangerous Drugs Act has been repeatedly amended to increase penalties for illicit drug use, is famous for a zero-tolerance approach to illicit drugs. The law allows police to detain those suspected of drug use for up to two weeks, to force them to submit to urine testing, and to send those who have used illicit substances to compulsory treatment camps. Repeat offenders found in possession of any amount of illicit substance face mandatory flogging and imprisonment. Possession of 15 grams (1/2 an ounce) of heroin or 200 grams (seven ounces) of marijuana is punishable by death, and some 230 people have been hanged under this statute since 1975. In January 2005, authorities announced that possession of a syringe would also be punishable by incarceration.

Nonetheless, increases in HIV among IDUs in 2005 moved Malaysian authorities to reexamine their approach, and brought striking new interest in harm reduction. While data were not available for 2005, IDUs represented 75 percent of cumulative HIV cases at the end of the previous year. In September 2005, Malaysia's health minister, Chua Soi Lek, announced that the government would support two pilot harm reduction initiatives. The first, which began in October 2005, will provide methadone to more than 1,000 drug users for a six-month period. The government allocated nearly \$650,000 to a total of 16 clinics, each of which will treat up to 120 clients, and agreed to subsidize treatment for those who could not afford it.

The second project, slated to begin in January 2006, will fund programs to provide clean needles and condoms to IDUs in three cities. Chua said that the project would be monitored and evaluated by a task force comprising officials from his ministry, the National Drug Agency, and the police. If a favorable evaluation results after the 12-month pilot stage, the government will expand the project nationwide.

Plans for harm reduction have proven contentious. Some religious and political leaders have lobbied instead for further strengthening of Malaysia's drug laws, with one member of parliament suggesting in March 2005 that a useful deterrent would be public beheadings of drug users and

## Malaysia, HIV, and IDUs

1) Total population	25.3 million
2) Estimated number of IDUs	195,000
3) Total registered HIV cases	65,000*
4) IDUs as share of total registered HIV cases	75%*

\* Data as of December 2004 (more recent data unavailable)

Estimates of HIV cases and number of IDUs vary sharply, and are frequently higher than those provided by national governments.

Sources: 1) UN Dept. of Economic and Social Affairs, 2005; 2) UNODC HIV/AIDS Unit, September 2005 (midpoint estimate); 3) Malaysia Medical Association, December 2004; 4) Malaysia Medical Association, December 2004

## voices from the front

### IS HARM REDUCTION “UN-MUSLIM?” A MALAYSIAN INFECTIOUS DISEASE EXPERT OFFERS RELIGIOUS GROUNDS FOR ACTION

*In February 2005, a Malaysian drug treatment provider told a subcommittee of the U.S. Congress that harm reduction was “un-Muslim” (see page 13). The following are excerpts from a written rebuttal provided by Adeeba Kamarulzaman, chief of the infectious diseases unit at the University of Malaya Medical Center.*

As an HIV/AIDS physician practicing in Malaysia, and a Muslim, I wish to clarify some of the statements . . . with respect to the problem of drug use in the region and Islam’s perspective on these issues. In many parts of Asia, unsafe injecting practices have been the primary risks driving the explosive HIV/AIDS epidemic. . . . Drugs and indeed alcohol are *haram* (forbidden) for all Muslims, as Islam forbids any action that would result in harm or destruction. However, beyond the simple *haram* and *halal* (permitted) of substances such as drugs and alcohol lies the fundamental objective of Islamic divine laws, which is the protection and preservation of faith, life, intellect, progeny, and wealth. . . .

Harm reduction can therefore be accepted as a necessity in order to preserve [these aspects of life] that are threatened by the twin epidemics

of drug use and HIV/AIDS. In Islam, life and good health must be protected and promoted in all circumstances, and this includes prevention and treatment of any illness and disease.

The principle of injury in Islam (*darar*) asserts that no one should be hurt or cause hurt to others (*la darara wa la dirar*) . . . The law requires that any injury should be mitigated to the extent possible. A legal dictum in Islam gives the provision that “a lesser harm may be tolerated in order to eliminate a greater harm. . . .” Harm reduction programs, for which there is compelling scientific evidence . . . are therefore not against Islamic principles . . . It is of greater harm for Muslims to allow more injecting drug users and their family members to be infected with HIV/AIDS than it is for them to allow a harm reduction program to take place.

traffickers. A leading senior cleric, Hausaani Zakaria, strongly recommended in May 2005 that “HIV-infected persons should be held confined on an isolated and remote island and not endanger society with their infection.”

By contrast, a number of influential Malaysians have argued that current drug laws have failed to deter drug use and are inadequate to address HIV. In June 2005, Marina Mahathir, then head of the Malaysian AIDS Council and daughter of a former prime minister, called for reform of the

Dangerous Drugs Act. She was particularly critical of provisions allowing criminal charges to be filed against an individual in possession of a syringe for any reason. Such policies, she said, limit the ability of IDUs to obtain clean needles and syringes and greatly increase their risk of HIV. Mahathir strongly supported the methadone and needle exchange pilot programs. So did Adeeba Kamarulzaman, the head of the Infectious Diseases Unit at the University of Malaya (*see box above*).

## Vietnam

The Vietnamese government's HIV prevention strategy for 2005–2010 explicitly supports harm reduction, including needle exchange and methadone maintenance, as important parts of HIV prevention for IDUs. The strategy also contains a commitment to include IDUs in all HIV prevention and care services.

Since passage of the strategy, the government has reaffirmed and further articulated its commitment. In June 2005, Pham Manh Hung, deputy director of the Party Central Committee's Commission for Science and Education, announced at a Hanoi press conference that methadone would be made available for drug-dependent individuals across the country. Pham's comments were reinforced in October when government officials and the World Health Organization issued a joint statement emphasizing that substitution treatment for drug users would be a vital part of the country's response to HIV in the future. In July 2005, the Ministry of Health submitted a draft law to a committee of the National Assembly that included provisions to protect the human rights of people with HIV; strengthen HIV-related confidentiality; expand HIV treatment, care, and support; and hasten the implementation of HIV prevention, including needle and syringe programs and methadone maintenance. The National Assembly is expected to approve the law, which is scheduled for a vote in May 2006.

To a limited extent, Vietnamese rhetoric has been matched by action. Some 30 nee-

dle exchange programs operate in the country, many using peer outreach workers. A cross-border program offering direct distribution and pharmacy vouchers for needles and syringes, funded by the Ford Foundation (for services) and the U.S. National Institute on Drug Abuse (for research and evaluation) has operated since 2001 in northern Vietnam and southern China, offering access to about 25,000 needles/syringes per month. In many project sites, HIV infection rates have declined. An AusAID-funded project offers harm reduction training and education to public security and prison personnel in Vietnam, Burma, and China, though it provides no condoms or needles in Vietnam. Vietnamese pharmacies sell syringes very cheaply—for about one-twentieth the price of a shot of a heroin—though this does not mean that drug users are willing to risk buying them or have enough money to do so after purchasing drugs. Most pharmacies are also closed during the hours of greatest IDU activity.

As in other Asian countries, harm reduction programs do not reach anywhere near all those in need, and government support

## Vietnam, HIV, and IDUs

1) Total population	84 million
2) Estimated number of IDUs	113,000
3) Total registered HIV cases	103,000
4) IDUs as share of total registered HIV cases	52%

*Estimates of HIV cases and number of IDUs vary sharply, and are frequently higher than those provided by national governments.*

**Sources:** 1) UN Dept. of Economic and Social Affairs, 2005; 2) UNODC HIV/AIDS Unit, September 2005 (midpoint estimate); 3) Vietnamese Ministry of Health, November 2005; 4) Ministry of Health/National Institute of Hygiene and Epidemiology, 2005

for harm reduction is counterbalanced by punitive campaigns that cast drugs and drug users as “social evils.” While it is legal to buy or possess syringes, it is illegal to use them to inject illicit drugs, and IDUs are reluctant to carry needles for fear of arrest. Vietnamese law enforcement conducts periodic crackdowns that result in many IDUs being sent to rehabilitation centers (“06 centers”) that human rights groups charge are more like forced labor camps and offer little or nothing in the way of real substance abuse treatment. UNAIDS estimates that more than 55,000 drug users are currently held in such centers, where they are kept for years without clear terms for their release and without provisions for treating the many who are HIV positive. Terms of detention are longest in the south, where approximately 35,000 were held in Ho Chi Minh City alone in 2005. Researchers estimate that relapse rates upon release from these centers are in excess of 90 percent, making transitional programs to prevent relapse and HIV transmission sorely needed.

A 1997 law prescribes the death penalty for anyone found in possession of 100 grams (3.5 ounces) of heroin or five kilograms

(11 pounds) of opium. According to Amnesty International, half of the 88 people executed in Vietnam in 2004—a year in which the country ranked third, behind China and Iran, in number of executions carried out—were convicted of drug offenses.

The selection of Vietnam as a focus country for the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR)—the only PEPFAR country in which injection drives the HIV epidemic—has not increased the accessibility of harm reduction. By U.S. policy, none of the \$34 million awarded to Vietnam can be used for needles or syringes. The PEPFAR program includes plans for substitution treatment and the Ministry of Health has authorized a pilot program in Hai Phong, though the commitment has yet to translate into needed services.

PEPFAR monies were used primarily to support HIV treatment in 2005, with the goal of reaching 1,500 patients with ARV and expanding a pilot project to curb mother-to-child HIV transmission. In the future, it will be essential for the program to reach detainees in prisons and drug rehabilitation centers, where neither needle exchange or methadone is now available.



Protest by Thai Drug Users Network, Bangkok, Thailand



# Harm Reduction Overviews

At a special session of the United Nations General Assembly in 2001, member states committed themselves to action on HIV, including expansion of harm reduction and availability of sterile injection equipment. At the close of 2005, despite evidence of harm reduction's effectiveness, much progress was still needed. Strikingly, none of the developing/transitional countries where IDUs are the majority of HIV infections has taken harm reduction programs to national scale.

Estimates of total numbers reached by harm reduction services are unreliable. Many programs lack the resources or staff to respond to national or international surveys. Providers may use different definitions of "client," "treatment," or those they count as having been "reached." Interruptions in funding or supplies of syringes or medications, and crackdowns on IDUs or those who serve them, can interrupt services or discourage attendance. More broadly, the number of registered HIV infections among IDUs is often a function

of testing sweeps and police roundups rather than the result of careful assessment.

Nonetheless, available data is clear. In key areas of HIV prevention and treatment, such as opiate substitution treatment or harm reduction programs for prisoners, the need for services far exceeds supply. Illicit drugs are widely available. Services to protect drug users are not.

The following overviews report on a number of areas central to IHRD's harm reduction approach.

## Community Mobilization: Organizations of Drug Users and People with HIV

One of the enduring lessons of the HIV epidemic is that the expertise and engagement of those affected is critical to effective treatment and prevention. In countries with injection-driven epidemics, where those infected and affected by HIV are often “hidden” populations—drug users, sex workers, prisoners, and migrants—enabling community engagement means confronting particular challenges. People who use drugs are more easily engaged by peers than by officials who frequently seek to control them rather than to offer assistance. Even in international meetings and national initiatives where greater involvement with people living with HIV is a priority, the voices of drug users are often silenced.

Despite social stigma, institutionalized discrimination, harassment from law enforcement, and lack of economic resources, a growing number of organizations are advocating for the needs of drug users and PLWHA. The Collaborative Fund for HIV Treatment Preparedness, the American Jewish World Service, the Levi Strauss Foundation, the Mainline Foundation, the Australian Federation of AIDS Organizations, IHRD, and others have provided financial and technical assistance to help create organizations run by and for current and former drug users. These drug user groups also work to support each other.

### Thailand

The Thai Drug Users Network (TDN) won international attention for its criticisms of the government’s 2003 war on drugs that included use of blacklists to arrest or intern more than 50,000 alleged drug users; forced testing at nightclubs and bars; and the killing of nearly 3,000 Thais in gangland-style executions without trial. Galvanized by the brutality of the government and the fact that the Thai minister of health was ignoring an HIV epidemic

that had infected one in two Thai injectors since the late 1980s, TDN applied for and won a \$1.3 million Global Fund grant—the first ever awarded to a drug-user organization—to support involvement of drug users in the planning and implementation of harm reduction services and policy advocacy.

The battle to secure access to treatment in Thailand, whether to HIV services or to participation in clinical trials, is far from over. In an October 2005 meeting, for example, a doctor who dispenses methadone at a major Bangkok hospital described working with active drug users as “trying to corral dogs into their cage.” The comparison, not lost on TDN members present, prompted one to respond, “Of course, if that’s how you perceive us, you will never understand us, as dogs and people speak a different language.”

### Bulgaria

In Sofia, the group Hope organized methadone patients, current and former drug users, and their allies to monitor the quality of drug treatment and medical services and to document abuses. Hope has also pressed for legal reform in the wake of a Bulgarian law passed in April 2004 that re-criminalized possession of any amount

of illicit drugs, imposing a minimum penalty of three years in prison. The new law also added a “conspiracy” charge that imposed prison sentences of 10 to 20 years for drug crimes committed by multiple people, a proviso that meant that three teenagers sharing a marijuana cigarette might face up to 20 years’ imprisonment. Calling attention to the severity of the punishment and the ways in which incarceration would fuel HIV, Hope helped organize public demonstrations that drew more than 2,000 protesters, and collaborated with the Open Society Institute–Sofia on a project to monitor and publicize the impact of the new law. On June 26, 2005, the UN’s International Day Against Drug Abuse and Illicit Drug Trafficking, Hope organized more than 300 drug users to sign a petition presented to the media requesting political asylum in Iran. There, they noted, methadone and syringe exchange were more freely available.

## Ukraine

In Kherson, the first patients receiving buprenorphine organized a group, Awake!, to raise community awareness and rally support for the program. The Kherson program, one of two pilot buprenorphine projects operating in summer 2005, experienced a crisis after supply problems forced doctors to sharply cut doses to patients. The program sponsor, UNDP, announced that it would have no medicine left by September. Awake! passed out leaflets in the street; joined with drug treatment physicians, AIDS advocates, and parents of drug users to publicize the benefits of substitution treatment; and appeared on roundtables and in the media urging that the program be continued. The European AIDS Treatment Group, the International HIV/AIDS Alliance, and IHRD joined the fight, and the push succeeded in ensuring that the Kherson program was among the seven supported by Ukraine’s Global Fund

grant. Awake! members and other patients of the program experienced no treatment interruption. Dozens more opiate-dependent people and their family members have contacted Awake! to learn more about treatment with buprenorphine.

## Russia

FrontAIDS—the network of activists that made headlines by conducting civil disobedience protests in Kaliningrad and elsewhere in 2004—continued to use direct action to draw attention to the lack of affordable HIV treatment, government failure to provide substitution treatment, and discrimination against people with HIV in Russia. In May, some 35 activists from regions including St. Petersburg and Irkutsk, Siberia, many traveling across the country at their expense, gathered to form a “Bridge of Shame,” chaining themselves in front of the Ministry of Health in Moscow to protest the lack of ARV availability in the country. Among their demands were the registration and production of generic ARV in Russia; adoption of WHO HIV treatment and care protocols, including access to substitution treatment; and government commitment to an emergency meeting regarding provision of HIV treatment.

## China

In the southwest of the country, near the Burmese border, the Ruili ARV Treatment, Education and Self-Support Group Construction Project was established in 2005. The project created the first group for people with HIV in the city of Ruili, where the majority of those living with HIV are IDUs and ethnic minorities. The group’s objectives include increased treatment education and adherence for the small number receiving ARV, activities to increase demand for treatment, and outreach in drug rehabilitation centers and labor camps.

# voices from the front

## CONSULTING WITH PEOPLE WHO USE DRUGS: RECOMMENDATIONS FOR EFFECTIVE ENGAGEMENT

*In 2005, The Canadian HIV/AIDS Legal Network (CHALN) consulted with drug user organizations in Canada and internationally to frame key issues around inclusion of people who use drugs in policy and program work. In December, CHALN issued Nothing About Us Without Us, an examination of the public health, ethical and human rights imperatives of greater and more meaningful involvement of people who use illegal drugs. An excerpt of drug users' suggestions for effective collaboration is below.*

### Consulting with people who use drugs: Do's and Don'ts

Do	Don't
Invite several of us	Invite just one of us
Invite a user group to select representatives	Always hand-pick the same user you know and are comfortable with
Invite an active user	Only invite former users
Invite former users in addition to active users	Invite them instead of inviting active users
Hold a meeting or consultation in a low-key setting or in a setting where users already hang out	Hold it in a government building
Provide an honorarium—contrary to most people who attend your meetings, we are not paid to attend by our jobs, but still need to look after our needs	Assume that we don't need an honorarium or would just spend it on drugs (or that it wouldn't be justified even if we did)
Guarantee confidentiality	Identify users and what they said in the proceedings of the meeting
Show flexibility with meeting times	Hold a meeting at 9 a.m., or on the day when welfare checks are issued
Assign us a support person or provide training if you ask us to be on a committee or board	Run your committee or board meetings without acknowledging that it may be the first time for us to be on a committee or board

For the full text of the recommendations and the CHALN report, see [www.aidslaw.ca](http://www.aidslaw.ca).

## ARV for IDUs

Ten percent of the world's HIV cases are among IDUs. Yet in nearly all countries—including those where they comprise a significant majority of all cases—IDUs have been disproportionately less likely to have access to ARV treatment. In many developing/transitional countries with injection-driven epidemics, ARV has been provided to drug users last if it has been offered to them at all.

### History of Neglect

Treatment disparities are due in part to social and economic isolation, including fear by drug users that authorities may harass or detain them if they seek HIV testing or treatment. Yet medical providers in countries with injection-driven epidemics have often denied services to IDUs who have sought ARV, claiming that drug users are unproductive and undeserving, or that their chaotic lifestyles make them unable to adhere to treatment. These claims have been made even where drug users are subject to more extensive controls than others with HIV, and despite studies showing that drug users, when offered appropriate supports, enjoy the same benefits from and adherence to ARV as other people with HIV.

- In China, for example, a 2004 report by Human Rights Watch found that drug users detained in compulsory detoxification centers were tested for HIV but not told the results or offered treatment.
- In Russia, where IDUs represented 90 percent of cumulative HIV infections in 2002, a report by the Central and Eastern European Harm Reduction Network (CEEHRN) noted that none of those in Moscow or St. Petersburg on ARV were IDUs. A Human Rights Watch report from 2004 found that active IDUs were

still excluded from ARV in St. Petersburg. The chief physician of the City Health Committee, Elena Vinogradova, told researchers: “We know who can be trusted and who can not.”

- In Malaysia, a 2003 report commissioned by the HIV/AIDS Task Force of the Millennium Development Project noted that prisons and compulsory treatment centers tested detainees for HIV, segregated those who tested positive, but offered them no ARV.
- In Vietnam, a 2001 assessment by the Centre for Harm Reduction at the Burnet Institute noted that forced treatment centers compelled detainees to take HIV tests, but did not offer any treatment to the 40 to 80 percent who tested positive.

### Increased options in 2005

In light of these reports, ARV programs can be said to have failed drug users rather than the other way around. Accurate assessment of how many IDUs had access to ARV in 2005 was further complicated by the fact that many governments did not collect the information or failed to make it available. Nonetheless, treatment options for drug

# voices from the front

## A STEP TOWARD EQUITABLE TREATMENT ACCESS

The Strategic Treatment Education Project (STEP), a peer treatment program created by the European AIDS Treatment Group (EATG) with technical support from IHRD, continued work in Eastern Europe and expanded to Central Asia in 2005. Under this program, experienced HIV treatment educators train local educators with links to communities where need for treatment is greatest. Initial training sessions focus on the basics of HIV treatment, case studies, group work, and problem-solving on treatment protocols, as well as on practical issues like interactions of HIV and street drugs; treatment of those co-infected with hepatitis C and HIV; and user-friendly perspectives on ways to increase treatment adherence and diminish negative side effects. STEP trainees are then linked through the Internet for ongoing education and support with a panel of community educators using an electronic listserv (STEPnet) moderated by a facilitator.

A training conducted in July 2005 in Bishkek, Kyrgyzstan, brought together 33 treatment educators and constituted one of the largest gatherings of people with HIV in the history of Central Asia. In addition, STEP launched its online training course for Central Asian treatment educators in October. The EATG plans to have the program transition entirely to Russian-speaking regional experts by 2006, and will continue to emphasize the treatment needs of IDUs. With support from WHO, STEP trainers have also developed a training manual for a “knowledge hub” on harm reduction, coordinated by the Central and Eastern European Harm Reduction Network, IHRD, and AIDS Foundation East-West.

users clearly improved in 2005 in a number of developing/transitional countries with injection-driven epidemics. Grants from the Global Fund proved particularly important in allowing the creation of HIV treatment models more inclusive of IDUs.

In Georgia, authorities report that all those identified as needing ARV have access to treatment. While claims of universal access do not account for those IDUs afraid of or unable to be tested, it is noteworthy that universal access is a goal supported by the government, and that IDUs—nearly 50 percent of those receiving ARV as of November—receive treatment somewhat proportionate to their share of total HIV cases.

In China, using Global Fund grant money, authorities have included IDUs

explicitly among those to be reached by treatment initiatives providing ARV free of charge. Some provinces are considering provision of treatment in compulsory detoxification centers.

In Russia, the GLOBUS project, formed by NGOs with the support of the Global Fund, launched a treatment initiative in 2005. The GLOBUS model was unusual because it prioritized inclusion of drug users in ARV treatment, and recognized the expertise of peer educators and people with HIV as well as physicians. The treatment initiative was guided by the Open Health Institute, with technical assistance provided by IHRD and international treatment experts. More than 70 percent of the 210 patients enrolled by the end of December 2005 were either current or former IDUs.



## Prisons, HIV, and IDUs

Most developing/transitional countries with injection-driven epidemics have responded to growing drug use by tightening legal controls, and by punishing possession of even small amounts of drugs with incarceration or forced institutionalization.

Efforts to control drug users through incarceration, however, only fuel HIV epidemics, placing large numbers of infected and uninfected individuals in environments where risky behaviors such as drug use, sex, and tattooing continue but where means of protection are often unavailable. In all prisons—whether the special facilities constructed for drug users in Indonesia or the general facilities where drug users make up a large number of those imprisoned in countries like Russia—inmates report injecting drug use. Frequently, prisoners will share or rent needles that are homemade, contaminated, or even rusty with overuse.

The results of the failure to implement harm reduction in prisons are clear.

- In Indonesia, a June 2005 assessment by Australian researchers found that as many as 10 to 20 prisoners rented a single syringe. Tattoo needles, too, were routinely used on as many as three to five inmates.
- In Ukraine, a 2004 survey of prisoners in six different regions found that 11 percent reported using injection drugs in the past year, with many reporting sharing of injecting equipment.
- In Kyrgyzstan, according to Ministry of Justice reports, half of the country's

registered HIV cases in 2004 were among those in prison.

- In Latvia, a 2003 study by the Latvian Institute of Philosophy and Sociology found that 14 percent of prisoners injected in prisons and that 80 percent of those prisoners shared needles.
- In Russia, a 2002 study of 10 Russian prisons by Médecins Sans Frontières found that one in ten prisoners reported injecting drugs, and two-thirds of those who injected shared needles. As many as 13 percent injected for the first time while incarcerated.
- In Lithuania, an HIV outbreak in 2002 resulted in the diagnosis of 299 HIV cases in Alytus prison, nearly double the total number diagnosed in Lithuania in the previous decade.

Steps that can reduce HIV infection in prisons have been long acknowledged. As early as 1993, WHO's *Guidelines on HIV Infection and AIDS in Prisons* recommended that countries where needle exchange was offered to IDUs in the community also provide sterile injection equipment to prisoners during detention and upon release. In May 2005, WHO Europe issued its *Status Paper on Prisons, Drugs, and Harm Reduction*, noting that "the evidence



Prisoner in cell, Bali, Indonesia

of effectiveness of harm reduction action is now overwhelming.” Among the report’s recommendations were that all prison systems provide opiate substitution treatment and needle exchange programs equivalent to those available in the community. The prestigious medical journal *The Lancet*, in a July 2 commentary, called the WHO Europe paper “one of the most important documents on prison health ever published.”

Nonetheless, few prisons have implemented these lifesaving recommendations. Among developing/transitional countries with injection-driven epidemics, only Moldova had both needle exchange and methadone maintenance in prisons in 2005, with methadone going to fewer than 10 prisoners. Belarus provides needle exchange in a single prison. Indonesia began limited methadone maintenance treatment in two prisons in 2005, and Armenia began needle exchange in three penal institutions. Kyrgyzstan has needle

exchange programs in 11 prison colonies. Iran, which has the largest prison-based methadone program of any developing/transitional country with an injection-driven HIV epidemic, plans to pilot needle exchange in 2006. With funds and technical support from IHRD, the Canadian International Development Agency, and the Canadian HIV/AIDS Legal Network, among others, Ukraine has also pledged to begin needle exchange in two prison colonies in 2006; experts held trainings and an international conference on the subject in 2005.

These developments notwithstanding, harm reduction programs in prisons remained highly limited in the countries where they were needed most in 2005. Outside of Iran, fewer than 50 prisoners had access to substitution treatment in developing countries where the majority of HIV cases were among IDUs. Availability of needle exchange also lagged far behind need.

## Harm Reduction in Prisons

### Developing/Transitional Countries with Injection-Driven HIV Epidemics, 2005

#### Central and Eastern Europe and the former Soviet Union

	HIV cases among inmates*	Needle exchange availability in prisons	Substitution treatment in prisons
Armenia	n/a	yes	<b>no</b>
Azerbaijan	25	<b>no</b>	<b>no</b>
Belarus	2,833	yes (one prison)	<b>no</b>
Estonia	420	<b>no</b>	<b>no</b>
Georgia	n/a	<b>no</b>	<b>no</b>
Kazakhstan	600	<b>no</b>	<b>no</b>
Kyrgyzstan	170	yes	<b>no</b>
Latvia	511	<b>no</b>	<b>no</b>
Lithuania	254	<b>no</b>	<b>no</b>
Moldova	159	yes	yes (<10 patients)
Poland	981	<b>no</b>	yes (< 25 patients)
Russia	42,000	<b>no</b>	<b>no</b>
Tajikistan	60	<b>no</b>	<b>no</b>
Turkmenistan	n/a	<b>no</b>	<b>no</b>
Ukraine	4,000	<b>no</b>	<b>no</b>
Uzbekistan	56	<b>no</b>	<b>no</b>

#### Asia

	HIV cases among inmates*	Needle exchange availability in prisons	Substitution treatment in prisons
China	n/a	<b>no</b>	<b>no</b>
Indonesia	8,850	<b>no</b>	yes (<25 patients)
Iran	n/a	yes	yes
Malaysia	1,834	<b>no</b>	<b>no</b>
Vietnam	n/a	<b>no</b>	<b>no</b>

\* Numbers of those with HIV in prisons are highly inaccurate, often reflecting cases detected rather than total numbers of those infected.

n/a = not available

#### Sources:

HIV estimates: Medical department of national prison authorities (Lithuania, Moldova, and Ukraine), December 2005; UNODC HIV/AIDS unit, September 2005; (Data collected between 2000-2005). Needle exchange and substitution treatment availability: National prison authorities and reports to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

# voices from the front

## FROM RESEARCH TO ACTION ON PRISON NEEDLE EXCHANGE

*Health Canada, the UN Office on Drugs and Crime, UNAIDS, and OSI co-sponsored a global policy dialogue on HIV in prisons in Toronto in October 2005. The meeting brought together high-level prison officials, representatives from ministries of justice, judicial reformers, and NGOs from 11 countries. James Motherall, a former prisoner and prison advocate, addressed the group. An excerpt of his remarks follows.*

A number of speakers today have mentioned the need for studies about the effectiveness of harm reduction. That's understandable, but there have been many studies already that all say the same things that prisoners already know. The missing component for HIV and hepatitis prevention among prisoners is action. Some harm reduction methods are available in prison [in Canada] such as condoms, bleach for cleaning needles, methadone programs, and education. The problem is these methods do not go far enough.

Corrections Canada has recently approved pilot projects for tattoo parlors in some of its prisons to reduce the spread of hepatitis. Normally this would be a step forward except they have said that they won't do facial tattoos, numbers, gang signs, or tattoos that could be viewed as obscene. These restrictions take away the kinds of tattoos that prisoners would normally want done. This means tattoos will continue to be done underground, constituting an unsafe practice.

Corrections has not yet brought in needle exchange programs. The claim is that to do so would be condoning the use of drugs or that syringes could be used as weapons.

Both arguments are not worth the breath it takes to make them. Drug use in prison continues to be illegal and those caught using or smuggling in drugs will still be subject to whatever sanctions are in place. With respect to syringes being used as weapons, the same argument was made with bleach. The fear was that it would be thrown in the eyes of staff. That never happened. As for needles being used as weapons, why would someone want to use a needle when there are shivs [homemade knives] as long as 18 inches already available? Also, people say you shouldn't introduce needles into prison, but there are needles there already. If people wanted to use them as weapons they would use the dirty ones currently there. When guards do pat downs, or cell searches, it's a lot more dangerous for them if they get stuck with needles that have been reused so many times that they are likely to be infected.

Studies that tell us what the problem is do not save lives unless they are acted upon. The study I want to see is the one that tells me how successful needle exchange programs have been in Canada. That study will mean we did more than talking, and took action.

## Substitution Treatment

Medication for the treatment of opiate dependence, known as substitution treatment, is common practice in rich nations. In developing/transitional countries with injection-driven epidemics, substitution treatment remains strikingly inaccessible. Of the nearly 5.2 million IDUs estimated to live in countries where contaminated needles are the main source of HIV infections, fewer than 13,000 have access to one of the best and best-researched means of saving lives and controlling HIV infections.

This is not simply a problem of financing. Substitution treatment often remains unavailable even in countries where the Global Fund has pledged support. It is not a problem of evidence, since in study after study, substitution treatment is shown to reduce HIV risk, diminish social costs of drug use such as crime, and increase adherence to HIV treatment. Rather, it is a problem of mindset and commitment. European countries have vastly scaled up substitution treatment in the midst of their HIV epidemics—in France, for example, 80,000 patients have received buprenorphine treatment since 1996, and some 15,000 patients were receiving methadone in 2005. Germany legalized methadone treatment in 1987 and had about 60,000 patients on treatment in 2005.

Many countries with injection-driven epidemics, by contrast, have regarded substitution treatment as an issue of law enforcement rather than a problem of public health. Authorities insist that the risk of illegal diversion justifies failure to treat, or erect bureaucratic obstacles that severely limit scale and restrict service delivery. Many countries subject substitution treatment projects to “death by pilot,” requiring

them to complete elaborate paperwork, secure new authorizations from multiple ministries, and to demonstrate the efficacy of their approach year after year. Imagine if heart surgeons were asked to present data about the effectiveness of coronary bypass procedures in every country before being given permission to operate. The result in the case of restrictions on substitution treatment is more HIV infection, more suffering, and more deaths from overdose and AIDS.

Signs of progress were evident in 2005. China, Iran, and Vietnam reinforced their commitment to scaling up access to methadone maintenance treatment among IDUs as part of their national HIV prevention strategies. By December 2005, 6,500 patients were receiving methadone in China, and some 3,600 patients were on substitution treatment in Iran. Belarus, Vietnam, and Kazakhstan all authorized pilots in 2005, and will begin to provide medication in 2006. More broadly, many of the developing/transitional countries with injection-driven epidemics took small but important steps forward in 2005, initiating substitution treatment for the first time with either buprenorphine (Ukraine) or



Patient receiving methadone, Bishkek, Kyrgyzstan

methadone (Georgia and Malaysia). Indonesia and Moldova began provision of substitution treatment in prisons. Community advocates helped move the World Health Organization to add both methadone and buprenorphine to its list of essential medicines in June (*see page 14*).

At the negative end of the scale, substitution treatment remained illegal in Russia, one of the countries with the largest HIV epidemic among IDUs. While laws did not ban methadone use in Belarus or Ukraine in 2005, implementation of that treatment remained blocked by government opposition. In Lithuania, a parliamentary commission on drugs launched a highly publicized effort to restrict access to methadone. Advocacy by international experts and local HIV advocates rebuffed calls to close down the Lithuanian methadone programs, but political opposition and disinformation

campaigns continued. The majority of patients there are required to pay for treatment themselves, a factor further limiting access.

In China, authorities restricted entry to methadone to those who had passed through two institutionalizations in forced detoxification centers (or one forced detox and one forced labor camp). In some provinces, decisions about who entered treatment were left to the police.

Even the few countries with injection-drive epidemics deemed to have low-threshold, noncoercive, and low-cost access to methadone have had no success in bringing treatment to scale. For example, in Poland, despite an estimated 43,000 IDUs, fewer than 900 had access to methadone, a level that has stayed steady even as the number of HIV cases in the country has steadily climbed.



## Availability of Opiate Substitution Treatment

### Developing/Transitional Countries with Injection-Driven HIV Epidemics, December 2005

#### Central and Eastern Europe and the former Soviet Union

	Estimated IDU population	Total number of clients on methadone	Total number of clients on buprenorphine	Total number of clients on substitution treatment
Armenia	9,000	0	0	0
Azerbaijan	19,000	80	0	80
Belarus	46,000	0	0	0
Estonia	20,000	332	n/a	332*
Georgia	12,000	8	0	8
Kazakhstan	174,000	0	0	0
Kyrgyzstan	21,000	83	0	83
Latvia	11,000	55	0	55*
Lithuania	8,000	400	0	400*
Moldova	97,000	21	0	21
Poland	43,000	885	0	885
Russia	1,977,000	0	0	0
Tajikistan	53,000	0	0	0
Turkmenistan	11,000	0	0	0
Ukraine	397,000	0	165	165
Uzbekistan	87,000	0	0	0
<b>Total CEE/FSU</b>	<b>2,985,000</b>	<b>1864</b>	<b>165</b>	<b>2,029</b>

\* As of November 2005

n/a = not available

Note: Numbers do not include maintenance treatment prescribed by general practitioners or outpatient psychiatric units. In some countries such prescriptions are quite extensive.

#### Sources:

IDU estimates: UNODC HIV/AIDS Unit, September 2005 (midpoint estimates). Data collected from 2000-2004.

Substitution treatment: National AIDS/narcological centers and Soros foundations (CIS countries); the Central and Eastern European Harm Reduction Network (Baltics and Belarus); the Krakow Association for Drug User Support (Poland); and the AIDS Outreach Program (Moldova).

## Availability of Opiate Substitution Treatment

### Developing/Transitional Countries with Injection-Driven HIV Epidemics, December 2005

#### Asia

	Estimated IDU population	Total number of clients on methadone	Total number of clients on buprenorphine	Total number of clients on substitution treatment
China*	1,093,000	6,500	0	6,500
Indonesia**	580,000	~400	n/a, for detox only	~400
Iran	206,000	3,600	0	3,600
Malaysia	195,000	350	26	376
Vietnam	113,000	0	0	0
<b>Total Asia</b>	<b>2,187,000</b>	<b>10,850</b>	<b>26</b>	<b>10,876</b>

\* China figures exclude Hong Kong and Macao

\*\* As of July 2005

n/a = not available

Note: Numbers do not include maintenance treatment prescribed by general practitioners or outpatient psychiatric units. In some countries such prescriptions are quite extensive. In Malaysia, for example, pharmaceutical companies reported 2,500 methadone prescriptions in 2001, and as many as 15,000 for buprenorphine.

#### Sources:

IDU estimates: UNODC HIV/AIDS Unit, September 2005 (midpoint estimates). Data collected from 2000-2004.

Substitution treatment: European Network on Drugs and Infections in Prison; the Malaysian AIDS Council; and local programs.

*The Open Society Institute works to build vibrant and tolerant democracies whose governments are accountable to their citizens. To achieve its mission, OSI seeks to shape public policies that assure greater fairness in political, legal, and economic systems and safeguard fundamental rights. On a local level, OSI implements a range of initiatives to advance justice, education, public health, and independent media. At the same time, OSI builds alliances across borders and continents on issues such as corruption and freedom of information. OSI places a high priority on protecting and improving the lives of marginalized people and communities.*

*Investor and philanthropist George Soros in 1993 created OSI as a private operating and grantmaking foundation to support his foundations in Central and Eastern Europe and the former Soviet Union. Those foundations were established, starting in 1984, to help countries make the transition from communism. OSI has expanded the activities of the Soros foundations network to encompass the United States and more than 60 countries in Europe, Asia, Africa, and Latin America. Each Soros foundation relies on the expertise of boards composed of eminent citizens who determine individual agendas based on local priorities.*

[www.soros.org](http://www.soros.org)

*Founded in 1995, the International Harm Reduction Development Program (IHRD) of the Open Society Institute (OSI) works to reduce HIV and other harms related to injecting drug use, and to press for policies that reduce stigmatization of illicit drug users and protect their human rights. IHRD, which has supported more than 200 programs in Central and Eastern Europe, the former Soviet Union, and Asia, bases its activities on the philosophy that people unable or unwilling to abstain from drug use can make positive changes to protect their health and the health of others. Since 2001, IHRD has prioritized advocacy to expand availability of needle exchange, opiate substitution treatment, and treatment for HIV; to reform discriminatory policies and practices; and to increase the political participation of people who use drugs and those living with HIV.*

[www.soros.org/harm-reduction](http://www.soros.org/harm-reduction)



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